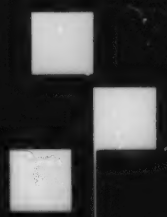

A Framework for Reform

Report of the Premier's Advisory Council on Health

December, 2001

Premier's Advisory Council on Health for Alberta

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Don Mazankowski, P.C., O.C.

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December 2001

The Honourable Ralph Klein
Premier of Alberta
307 Legislature Building
10800 - 97 Avenue
Edmonton, Alberta
T5K 2B7

Dear Premier;

As members of your Advisory Council on Health, we are pleased to provide our report on a framework for reforming Alberta's health system.

This report is a culmination of months of work by Council members - listening to presentations, reviewing various reports, examining trends and ideas from other places around the world, and finally, putting together our ideas and recommendations for reform.

As noted in our report, we have concluded that Alberta's health system is not sustainable unless we are prepared to make major changes in how we fund and deliver health services. The answer doesn't lie in further rationing services to Albertans. Instead, we strongly believe the answer lies in examining new ways of funding the health system, opening up more opportunities for health authorities, doctors, nurses and health care providers to deliver services in new and innovative ways, putting the patient first and giving Albertans more control and more responsibility for their own health. First and foremost, we believe the best long-term answer lies in encouraging Albertans to stay healthy and well.

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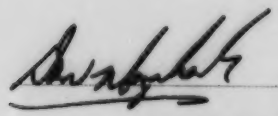
Alberta has an opportunity to lead the country in health reform and to make the health sector a key driver in the province's economy. We encourage you and all Albertans to review and discuss the package of recommendations we have proposed. But more importantly, we encourage you to take action. There are many positive features in Alberta's health system today. The challenge is to build on those strengths, take action, and secure a strong foundation for the future.



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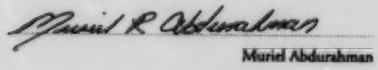

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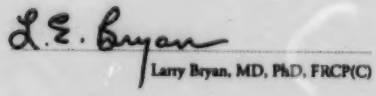

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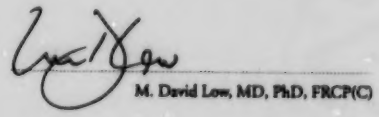

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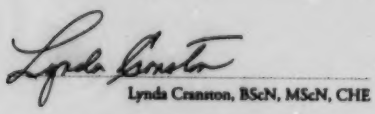

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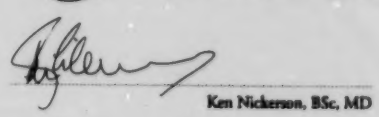

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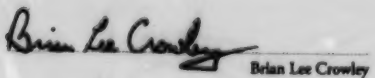

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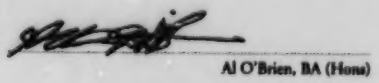

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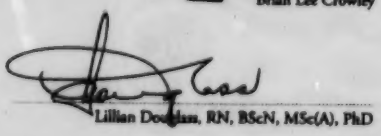

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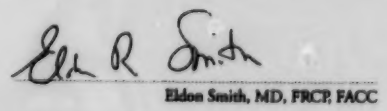

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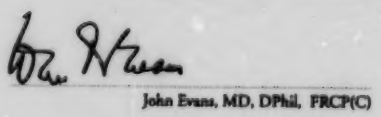

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- How does Alberta's health system measure up?
- Is the balance right?
- Is Alberta's health system sustainable?
- What factors are driving costs in health?

The Opportunity for People and Communities to Improve Their Own Health

Highlights

In the months since the Council began its work, we have learned a great deal about Alberta's health system. It's safe to say we have been thoroughly immersed, and sometimes overwhelmed, by information, ideas, questions, and challenges.

Alberta's health system is complex and diverse. It's an interwoven web where decisions or actions in one part of the system have a profound effect on others. It's wrapped up with emotional debates, dedicated professionals, long-standing traditions, old biases clashing with brand new ideas. And because it potentially affects all of us at some time in our lives, we can't look at it dispassionately.

In the midst of the debate and discussion, we should not forget that there is much to be proud of in Alberta's health system. It is staffed and led by dedicated and outstanding health providers and administrators. We have some of the best health authorities in the country. We provide leading edge treatments and technologies. Alberta is known as a national and international leader in health research. People who receive care rate it highly. There are thousands of babies born, surgeries performed, home care visits provided to older people in their homes, immunizations, visits to doctors, and inspections of restaurants each and every day.

At the same time, there are some clear challenges to address.

Many have suggested - and the Council agrees - that without fundamental changes in how we pay for health services, the current health system is not sustainable. Spending on health is crowding out other important areas like education, infrastructure, social services or security. If health spending trends don't change, by 2008 we could be spending half of the province's program budget on health. We do not believe that is acceptable. On top of that, demands for health care services are increasing and costs are going up. If there are new cures or new treatments, we want them all, even though having them all is driving up costs at a rate we simply can't afford. Provincial and federal governments are scrambling to keep pace with every new treatment, technology or drug that comes on the market.

If we restrict ourselves to a system where all the funding comes from provincial and federal taxes we have little choice but to ration services — and Albertans deserve better. We can't sustain a system where people are told: these services or treatments are available, they will diagnose health problems, cure illnesses, and make your life better, but they cost too much so you can't have them.

In spite of dramatic funding increases in the past few years, access continues to be a problem. Waiting times are too long for many procedures and this causes Albertans to worry about whether the health system will be there when they need it.

There are serious shortages of health providers. And those who work in the system are frustrated, demoralized and pessimistic about the future of their profession in the current environment.

There are serious flaws in the way the system is organized. It operates as an unregulated monopoly where the province acts as insurer, provider and evaluator of health services. There's little choice or competition. The focus is more on hospitals and health providers and less on people who need health services. As Albertans, we have little choice but to go where the public health system points us and wait in line if we need to.

In face of these challenges, the Council believes that Albertans have an opportunity to lead the country in true health reform. We have a well-earned reputation for tackling tough challenges, trying new approaches, and leading the way. Health is no exception.

There is no reason why we can't open up the system, seize new opportunities, and take advantage of new approaches. But to do that, we need to put all the ideas on the table and be prepared to debate the real pros and cons not just rehash the rhetoric of old arguments.

It's in that vein that the Council has prepared its first report. It tackles issues like sustainability, improving access and most importantly, improving the overall health of Albertans. It sets a clear goal for what we want to achieve, recommends some important steps to be taken, sets out fundamental changes in how we should organize and deliver health services, puts a strong emphasis on quality, and outlines options for deciding how we pay for the future of Alberta's health system.

Key themes

There are some key messages Albertans can take from this first report from the Premier's Advisory Council on Health.

- This report is not about quick fixes. We're looking at the best ways to sustain the system over the longer term not necessarily to reduce costs in the short term. Nor is our report about broad general ideas or approaches. It provides practical ideas and solutions to address problems and ensure sustainability of the health system for years to come.

- Our approach is built on the fundamental assumption that all Albertans should have fair and equitable access to health services. No one should be denied access to essential health services because they are unable to pay.

- The best long-term strategy for sustaining the health system is to encourage people to stay healthy. If we rely on simply treating people when they get sick, the increasing costs of new treatments and technology could bankrupt the system.

- The answer doesn't lie in rationing health care services. People are concerned about access and rightly so. All Albertans should have access to the very best health care when they need it. And it should be available to everyone on equitable terms.

- We need to extract maximum value for every dollar spent on health care. That's critical. But those measures alone will not be sufficient to match increasing demands and costs in the health care system.

- The burden of health care on the tax system is growing and will continue to grow with new treatments, new cures, new drugs and growing demands. We know what we want from the health system. Now we need to explore new ways of paying for it.

- It's time to think carefully about what can and should be covered by Medicare. The system was never designed to cover all aspects of health services, but people have come to expect that it will - and at no cost to individuals.

- We can't regulate to perfection. It's time to open up the system, take the shackles off, allow health authorities to try new ideas, encourage competition and choice, and see what works and what doesn't.

- We need to develop a patient-oriented system that encourages empowerment, accountability, and continuous quality improvement.

- We don't have to choose between the status quo and American-style, Swedish-style or United Kingdom-style health care. We can and we must create our own alternative - one that preserves the best of what we have but also makes sure we can sustain it for the future.

Recommendations for reform

1. **The first reform is to stay healthy.**

Research has become a powerful tool in showing the tremendous opportunity to improve health by taking action on broad determinants of health such as education and income and various lifestyle factors that affect health. Making healthier choices can significantly reduce the incidence of heart disease, strokes, high blood pressure, type 2 diabetes and several forms of cancer. This emphasis on staying healthy is at the heart of the Council's recommendations.

Specific recommendations focus on:

- making a strong commitment to the education of children and youth
- supporting children who live in poverty
- setting clear health objectives and targets for the next ten years
- providing Albertans with better information about how to stay healthy
- taking the lead in updating Canada's food guide
- strengthening health education in schools
- providing better incentives for people to stay healthy
- strengthening support for actions to reduce tobacco use.

2. **It's time to put "customers" first.**

It's time to shift the focus from hospitals and health care providers to individual Albertans who use and count on the health system.

Key recommendations include:

- providing all Albertans with a 90 day guarantee of access to selected health services
- reducing waiting times by introducing centralized booking, posting waiting times for selected procedures on a website, and allowing people to access services from any physician or hospital
- providing Albertans with more choice in the health care services they receive and where they receive them
- implementing new models of care like comprehensive primary health care and disease management approaches.

3. **Redefine what we mean by "comprehensiveness."**

Medicare was never designed to cover the full range of health services, treatments, drugs and technologies available today or envisioned for the future. If we want to make sure there is access to the best treatments available, we are going to have to make some choices about what services are covered and what services are not. Services that are not approved as insured services could be paid for by individuals or through supplementary insurance.

To make decisions on which services will be insured, Council recommends:

- Establishing an expert panel to review categories of services currently insured and decide if they should continue to be covered.
- Giving the expert panel ongoing responsibility for establishing criteria and determining whether each new treatment, service, or drug should be approved as an insured service.

4. **Invest in technology and establish an electronic health record.**

The lack of good information is a serious impediment in Alberta's health system. It means we can't track results, answer basic questions, or gather evidence about whether new approaches are effective or not. We also have no effective mechanisms in place for people to use in monitoring their own use of the health system or raising awareness about the costs of health care services.

Specific recommendations include:

- Developing and implementing an electronic health record
- Starting with a debit-style electronic health card to track and improve outcomes in health, allow individuals to track their own use of health services and the costs involved, and provide the essential tools if further steps are taken to introduce new approaches to funding health services. This essential first step would allow Albertans to see the cost of the health services they use and get regular reports on their use of the health system.

- Providing long term funding for technology and information technology systems
- Setting province-wide standards for information technology
- Continuing to support the work of the Alberta Heritage Foundation for Medical Research in assessing new technology.

5. **Re-configure the health system and encourage more choice, more competition and more accountability.**

It's time to open up the health system. If we're going to have regional health authorities - and we should - then they should have the mandate and the tools to do the job and be held accountable if they don't achieve the expected results.

Recommendations include:

- Setting clear and distinct responsibilities for government and regional health authorities
- Establishing multi-year contracts between the province and health authorities setting out performance targets to be achieved and budgets to be provided
- Facilitating cooperation among regional health authorities and using performance contracts to assess the effectiveness and viability of regions
- Encouraging health authorities to establish service agreements with a wide variety of providers including other regions, clinics, private or not-for-profit providers or facilities, and groups of health providers
- Encouraging health authorities to develop centres of specialization
- Implementing new models of care
- Encouraging an innovative blend of public, private and not-for-profit organizations and facilities to deliver health care services
- Encouraging groups of health care providers to establish "care groups" and offer a range of services to health authorities and individual Albertans
- Integrating mental health services with the work of regional health authorities.

6. **Diversify the revenue stream. Instead of rationing health services, we need to find better ways of paying for the health services Albertans want and need.**

We need to begin by extracting maximum value from every dollar we spend on health care. But containing costs, seeking efficiencies, and streamlining services will not be sufficient to offset increasing demands and rising costs. If we depend only on provincial and federal general revenues to support health care, we have few options other than rationing services. But if we're prepared to open up other sources of revenue, we have an opportunity to improve access, expand health care services, and realize the potential of new techniques and treatments.

Recommendations include:

- Ensuring that government continues to fund the majority of health care costs, but that increases are affordable
- Setting clear principles to guide decisions on new sources of revenue to support Alberta's health care system
- Exploring and implementing a "made in Alberta" approach to funding health care services based on options outlined by the Council and tied to Alberta Health Care premiums
- Working with other provinces to put national strategies in place to manage and contain increasing drug costs
- Allowing regional health authorities to raise additional revenues.

7. **Put better incentives in place for attracting, retaining and making the best use of health providers.**

Alberta, like almost every other jurisdiction in North America, is facing shortages of doctors, nurses and other health care professionals and providers. Combined with shortages, there are serious problems of dissatisfaction and low morale among health care providers. And current approaches for paying physicians are an impediment to new and effective models of comprehensive primary care and disease management.

Recommendations for addressing these issues include:

- Developing a comprehensive workforce plan that sorts out the roles of various health providers, anticipates future demands and guides decisions on post-secondary education
- Encouraging regional health authorities to develop and implement strategic initiatives to improve workforce morale for all health providers with the long-term goal of increasing work satisfaction and improving retention of the workforce
- Implementing alternative approaches for paying physicians and providing better alignment between physicians and regional health authorities
- Encouraging and empowering health providers to explore and implement a number of different approaches to organizing and delivering health care services.

8. **Make quality the top priority for Alberta's health system. Set standards, measure results, and hold people accountable for achieving better outcomes in health.**

Council believes that Alberta's health system should be defined by a relentless pursuit of quality.

Consistent with that overall direction, Council's recommendations focus on:

- Continuing to support research through a variety of sources and organizations to facilitate evidence-based decision making and support Alberta's role as a leading centre of health and medical research
- Establishing a permanent, independent "Outcomes Commission" with the responsibility of measuring outcomes, tracking progress and reporting results in achieving goals and targets on a long-term basis.

9. **Recognize and promote Alberta's health sector as a dynamic, powerful asset to the provincial economy.**

Currently, the health sector is viewed primarily as a cost centre consuming vital tax dollars. In reality, the health sector is a driving force in Alberta's economy. With new sources of revenue and expanded opportunities for organizing and delivering health services, the health sector has the potential to add considerably to Alberta's economy and help expand the province's reputation as a world-wide centre of research, expertise and leadership.

Specific recommendations include:

- Continuing to support research under the Alberta Heritage Foundation for Medical Research and taking steps to sustain Alberta's reputation as a leading centre for health and medical research
- Maintaining and enhancing support for education programs for health providers and medical schools and providing stability in how medical schools are funded
- Supporting the development of multi-disciplinary, integrated, provincial centres of excellence in health research
- Identifying and promoting public/private partnership opportunities for expanding research support
- Promoting commercialization of new products and services developed through health and medical research initiatives.

10. Establish a clear transition plan to drive the process of change, oversee implementation of recommendations, consider options, and monitor the impact.

Many of the Council's recommendations would result in fundamental changes in Alberta's health care system. People in the health system have been through considerable change and turmoil already and will be reluctant to embark on yet another course of change unless clear goals are set and an orderly plan for transition is implemented and managed.

Council strongly urges government to designate an individual responsible for overseeing and driving the transition process. Specifically, this individual would be responsible for:

- fleshing out the details of how a number of reforms could be implemented
- coordinating further studies and developing an Alberta approach to funding health care services based on options suggested by Council
- preparing and managing a detailed transition plan
- managing public expectations and informing the public on what changes will be made, when and what to expect as a result
- identifying and addressing barriers to implementation including legislation and regulations, labour codes and professional legislation, union agreements and conflicting policies among ministries
- ensuring that the system functions adequately and effectively through the transition phase
- managing and reporting progress on implementation of alternative payment plans for physicians.

Address Albertans' concerns

Taken together, the recommendations suggested by the Premier's Advisory Council provide a comprehensive package of fundamental reform to Alberta's health system. We believe the recommendations will address a number of key concerns and objectives in the health system.

Albertans are concerned about ...

Improving access to health services

To be addressed by...

- providing a 90 day care guarantee
- providing central booking services
- putting waiting lists on a website
- expanding new models of care including comprehensive primary health care and disease management approaches
- encouraging more choice and competition

Albertans are concerned about ...

Sustaining the health system

To be addressed by..

- introducing contracts between regional health authorities and government
- making sure increases in health funding are affordable
- considering new funding options for diversifying the revenue stream
- establishing an expert panel to decide which services are publicly insured
- working with other provinces to manage and contain drug costs

Albertans are concerned about ...

Improving health

To be addressed by...

- making a strong commitment to education
- providing support to children living in poverty
- setting ten year targets in key areas and tracking progress in improving overall health
- providing better information so people know what they can do to stay healthy
- providing better incentives for people to stay healthy
- taking concerted, sustained action to reduce tobacco use and using funds from increased tobacco taxes to fund these activities and other health promotion initiatives
- integrating mental health with regional health authorities

Albertans are concerned about ...

Addressing shortages of physicians and other health providers

To be addressed by...

- putting comprehensive workforce plans in place
- encouraging regional health authorities to address workforce morale and improving work satisfaction
- implementing new approaches for paying physicians
- expanding opportunities for physicians and other providers to deliver a wide range of health services

Albertans are concerned about ...

Getting maximum value for every dollar spent on health care

To be addressed by...

- introducing more competition and choice
- putting the customer first
- opening up more options for regional health authorities to contract with other regions and a variety of health providers and organizations
- encouraging an innovative blend of public, private and not-for-profit providers
- holding regional health authorities accountable for managing their budgets
- auditing contracts between government and regional health authorities on an ongoing basis

Albertans are concerned about ...

Giving Albertans more control and more responsibility for their own health

To be addressed by...

- introducing a debit-style electronic health care card
- providing regular reports on use of the health system
- providing a 90 day care guarantee
- expanding options in the health care system

Albertans are concerned about ...

Improving quality in the health care system

To be addressed by...

- introducing a new Outcomes Commission to monitor and measure results and report publicly
- introducing an electronic health record to track health outcomes and improve quality
- continuing to support research

Next steps

The initial directions and recommendations of the Premier's Advisory Council on Health are a culmination of more than a year of consultations, discussions, review and study. The Council is ready to assist the Premier and government in any way we can to flesh out details of the various recommendations, explore other options and assess the potential impact of new directions in health. At the same time, we have identified a number of areas where there are additional issues to consider.

We trust that these ideas and suggestions stimulate discussion and debate and help guide decisions about the future of Alberta's health care system. There are many positive features in Alberta's health system. We have a tremendous opportunity to build on those strengths, to develop a unique Alberta solution, and to lead the way for the rest of Canada in establishing a sustainable and efficient health care system for the 21st century.

Introduction

The Premier's Advisory Council on Health was established in August 2000 with a clear mission:

> *To provide strategic advice to the Premier on the preservation and future enhancement of quality health services for Albertans and on the continuing sustainability of the publicly funded health system.*

Within the context of that mission, The Council was asked to:

- assess the sustainablility of the health system
- propose potential approaches and strategies
- make recommendations on a preferred vision and propose a strategic framework for health and health services in Alberta, consistent with the principles of the *Canada Health Act.*

In the months since the Council was established, it has:

- Met with over 60 different organizations and numerous individuals representing various aspects of Alberta's health system
- Reviewed literally hundreds of reports and studies on health care
- Reviewed information about health systems in other countries
- Prepared a series of context papers on:
  - △ *How does Alberta's health system work?*
  - △ *How long do people wait?*
  - △ *How do Albertans use the health system and what do they think of the results?*
  - △ *Do we have a shortage of health professionals?*
  - △ *How does Alberta's health system measure up?*
  - △ *Is the balance right?*
  - △ *Is Alberta's health system sustainable?*
  - △ *What factors are driving costs in health?*

In its work to date, the Council has identified a broad range of issues and challenges to be addressed in Alberta's health system. Our intent is not to cover the waterfront in our first report. Instead, we have identified a number of critical issues:

- How can we sustain Alberta's health system in the longer term?
- What steps can be taken to improve the health system and provide better access to the services people want and expect?
- How can we improve the overall health of Albertans and encourage them to take more responsibility for their own health?

A number of additional issues were identified during the Council's work but have not been addressed in this first report. Issues such as elder abuse, health issues faced by several groups of people, and ethical issues surrounding heroic measures especially at the beginning and end of life were raised with the Council and deserve more indepth review and study. In particular, Council members are aware of serious health problems faced by Alberta's Aboriginal people. This issue warrants further consideration and should involve Aboriginal people directly in identifying priorities and proposing solutions.

Defining the goal

The Premier's Advisory Council on Health was given the mandate to review Alberta's health system and develop recommendations to ensure that the system meets Albertans' needs and is sustainable for the future.

As a starting point, we began by defining what we want to achieve with the health system.

The Premier's Council has developed the following statement to describe the goal we see for Alberta's health system. This is what Albertans, health providers and professionals, health authorities and government should be trying to achieve.

A sustainable health system that is a partnership between users and providers, that continues to evolve and improve, and results in better health outcomes for Albertans.

A system that ...

... is research and evidence based
... has the right incentives and
... is a model for Canada and the world.

***Sustainable* means**

- the system has sufficient resources - both dollars and people
- resources are available to respond to various forces that drive change and increase costs
- plans are in place to ensure there are adequate resources to support Alberta's health system in the longer term

***Health system* means**

- the health system is about more than just acute care and hospitals
- a range of different health services are integrated and available to Albertans in a seamless delivery system
- wellness must be an important component

***Partnership between users and providers* means**

- the health care system can only work well when users and providers recognize and respect each others' roles and responsibilities
- users (or consumers) must be treated as intelligent participants in their own health care - a health system that does not satisfy their needs is not acceptable
- providers have highly specialized knowledge and education - their professional advice and skill is indispensable in ensuring that users get health care appropriate to their needs

***Evolve and improve* means**

- there is an emphasis on evaluation and using research and information to continually improve the system
- experimentation, innovation, and a diversity of options should be encouraged

***Better health outcomes* means**

- there is evidence that treatments, decisions and programs result in better health outcomes for Albertans
- Albertans are satisfied with the services they receive and the outcomes are what they want and expect

***Research and evidence based* means**

- decisions are guided and driven by research and evidence
- Alberta takes a leadership role in health and medical research
- there is a continuing emphasis on collecting and using information to guide decisions
- the province capitalizes on the opportunity for research to drive the future of our economy

***Right incentives* means**

- the incentives in the health system are aligned with the results we want to achieve
- Albertans have the right incentives for using the health system appropriately and taking responsibility for their own health and well-being
- health care professionals and providers have the right incentives for providing care that produces better health outcomes and makes the most effective use of health system resources
- health authorities have the right incentives for setting priorities, integrating services, addressing the needs of people in their communities, working together, and managing resources effectively

***Model for Canada and the world* means**

- Alberta can and should play a leadership role in developing a sustainable health system with an innovative blend of public/private partnerships
- Alberta should support innovation, try new approaches, and share outcomes with other provinces
- Alberta has much to learn from others around the world and should embrace new ideas from other parts of the world
- Alberta should nurture an environment conducive to the growth and development of an Alberta-based world class health care industry

Part I
Background on five areas

As a framework for reviewing a number of issues in Alberta's health care system, the Council identified five broad areas for consideration:

- How to enable people and communities to take more responsibility for their health
- How to organize and deliver health services
- How to pay for health services
- How to ensure an adequate supply and the best use of health providers
- How to assess outcomes and improve quality in the health care system.

In the scope of those five areas, the following summarizes the key information, issues and options identified and discussed by the Council.

Enabling people and communities to take more responsibility for health

"When you are fighting this battle, [remember] that the ultimate goal of medicare must be the task of keeping people well rather than just patching them up when they're sick."

Tommy Douglas, quoted in Revitalizing Medicare, January 2001

We know key factors affect health.

It sounds like just good common sense, but perhaps the best way to sustain Alberta's health system over the longer term is to take steps to enable people and communities to stay healthy.

A comprehensive paper prepared for the Council (see appendices) summarizes a wealth of research on areas where broad determinants of health and individual lifestyle choices and behaviours have an impact on health. While the determinants of health have been recognized for several years, the impact of research on lifestyle has only recently unfolded and is dramatic in pointing out the tremendous potential for improving health.

Some of the key highlights of the paper are as follows:

- **Individual lifestyle changes can significantly improve health and the opportunity for improved health is enormous.**
  - Research on the effect of lifestyle on disease has reached a watershed point. There are now studies of similar design, quality and reliability as the best of those used to prove the benefits of drugs, surgeries, other treatments and diagnostics. These high quality studies show lifestyle changes can markedly reduce the incidence and severity of several major diseases and leading causes of death and disability especially heart disease, stroke, hypertension, diabetes and selected cancers.

- Many people know what to do - make healthier eating choices, get more active, avoid health risks and stop smoking. It's not clear why people don't necessarily act on what they know.
- There is constant, often conflicting and unevaluated news about what to do to stay healthy. People are often confused and don't know what information to trust or what is the most important information to act on. Information reaching health care providers is also uneven in quality.

- **Income affects health.**
  - Infant mortality is two-thirds higher in the poorest neighbourhoods than in the richest ones.
  - People in the lowest income groups are twice as likely to be smokers.
  - People with low incomes are more likely to: be heavy users of physician services, visit emergencies, be admitted to hospital, take multiple medications, and require home care services.

- **Having a job affects health.**
  - Life expectancy increases as the rate of employment increases.

- **Education matters.**
  - Life expectancy increases as the level of education increases.
  - Children whose parents have a low level of education are more likely to perceive their own health as poor and are less likely to have unbroken periods of good health.
  - People with higher education are more likely to use bike helmets, less likely to smoke, more likely to be active, and more likely to have a healthy body mass index.
  - People who have less than a high school education are more likely to have hypertension, less likely to have a PAP test, and more likely to engage in binge drinking.

- **Age and sex affect health.**
  - Depression is twice as common in women as in men.
  - The likelihood of going to hospital increases with age, having a lower income, having less than a secondary education, believing your health is poor, being a smoker, and being physically inactive or overweight.

Albertans are healthy, but there are problem areas and warning signs.

A closer look at trends in Alberta shows that overall, we are fairly healthy, but there are some clear health risks. (For more detailed information, check the Council's context paper: *How does Alberta's health system measure up?*)

- Alberta's rate of low birth weight babies is higher than the Canadian average. Babies born with a low birth weight are more likely to face continuing health problems.

- About 19% of Albertans age 15 and over said their activities were limited as a result of long-term physical or mental conditions or health problems. That's slightly higher than the Canadian average.

- Close to 12% of Alberta's children live in low income families (1998).

- Nearly 30% of Albertans over the age of 15 smoke.

- The leading causes of death are heart disease, cancer, stroke, injury, chronic obstructive pulmonary disease (including bronchitis and emphysema), pneumonia and influenza.

- For many illnesses, Alberta's rates are about the same as the Canadian average, and in some cases, they are lower. But Alberta's rates of stroke are higher than the Canadian average. More people die from motor vehicle collisions. More people are injured in falls. Our suicide rate is the second highest in Canada. More children get measles and mumps.

"... despite the connection of health status to many possible determinants, the most important factors related to it are income and illiteracy. Better health status seems to be associated with higher per capita incomes and less illiteracy."

Cynthia Ramsay, Beyond the Public-Private Debate

Keeping people healthy has a lower priority than acute hospital care.

We've included highlights of some of the things we know about how the health of Albertans compares with others and what research shows about factors that affect health. This information points to a tremendous opportunity to take action to help people stay healthy and well rather than just treating them when they are sick.

So what's being done about it?

We have to conclude, not enough.

Promoting good health and preventing illness are central functions of the health system. The federal government, provincial government, health authorities, and a variety of health organizations are involved in initiatives, programs and campaigns. But in most cases, these initiatives and programs are given lower priority than hospital care, emergencies, and surgeries. Since 1997-98, regional health authorities have consistently spent about 3% of their budgets on promotion, prevention and protection initiatives. In comparison, about a quarter of their spending goes to hospital inpatient services and another 19% is spent on diagnostic and therapeutic services. (For more information, check the Council's context paper: *Is the balance right?*) The objective should be to ensure that there is a sound balance between activities to improve health over the longer term and essential health services to treat people when they are injured or ill.

Options and alternatives

Council members heard and considered a number of options and alternative ways for improving the overall health of Albertans and encouraging people to make better decisions about their own health.

- **Provide better information.**

  Pick up a newspaper or watch the nightly news, and chances are good you'll hear some news story about a new way of staying healthy or a health risk to avoid - take certain vitamins or herbs, eat more oatmeal, switch to margarine (or switch to butter), antiperspirants cause breast cancer or Alzheimers' Disease. We've all heard the myths and misinformation and frequently one piece of advice is quickly followed up by a contrary opinion. While some of the basic messages are consistent - eat more fruit and vegetables, get more exercise, and stop smoking - people often are confused by the avalanche of information they receive. There are few trusted sources where people can get solid, evidence-based information about the best ways of staying healthy. Even the Canada Food Guide that many of us grew up with has not been updated to take into account the latest research. Health care providers also need access to evaluated and summarized high quality information on lifestyles and health.

- **Take action on factors that affect health, especially income and education.**

  Research shows that people with more education and higher incomes are healthier than those who have less education and lower incomes. Long term strategies to improve health should focus on making sure children and young people get a good education and are encouraged to complete high school and go on to some kind of post-secondary education and training. The number of children living in poverty in Alberta also is a concern that should be addressed as part of an overall strategy for improving health.

- **Follow through on programs to stop smoking.**

  A number of organizations have spearheaded plans and programs to encourage people to stop smoking or not start smoking in the first place, limit advertising of tobacco products, expand education on the impact of smoking, restrict or

prevent smoking in public places, or support community initiatives. While many of these ideas have been in place for some time, there has not been a concerted, province-wide effort and the potential outcomes of significantly reducing smoking have not yet been achieved.

- **Consider incentives for staying healthy.**

  A number of ideas have been suggested for encouraging people to take more responsibility for their own health. Some people have suggested tying health care premiums to actions to stay healthy, providing tax credits or other tax incentives, or using medical savings accounts or some other form of co-payment to give people more control over their own health care spending. Others have suggested there should be penalties for people who do not look after their own health.

- **Strengthen health education in schools.**

  Health education has been a part of the regular school curriculum for decades. But Council members have heard that health education is given a lower priority given the push for expanding emphasis on other areas, especially the sciences and technology. Health programs need to be updated and energized on a regular basis to ensure they reflect the latest information and are interesting for children and young people. More could also be done in schools to encourage and support daily physical exercise.

- **Explore a range of ways of encouraging people to stay healthy.**

  Council heard a number of ideas for encouraging people to stay healthy, including the following:

  - work with existing community organizations such as seniors' organizations
  - make better use of the range of health care providers and expand their role in helping people stay healthy
  - support federal policies directed at reducing economic and social disparities
  - work with industry and business organizations to enhance safety and equality in the workplace
  - continue policies to clean up the environment and ensure a safe physical environment
  - continue to place high priority on immunization, prevention of infectious diseases, and safe water and food
  - ensure that Alberta Health and Wellness has the capacity in the provincial epidemiology service to respond to emerging infectious diseases, in cooperation with federal and international resources
  - continue efforts to reduce unintentional injuries and violence.

Council recognizes that many of these initiatives are already underway and should be strengthened and supported as part of the government's overall plans to promote good health and prevent illness and injury.

In summary ...

- The best way to sustain the health system in the longer term is to encourage more people to stay healthy.
- Ensuring that every child gets an opportunity to succeed at school and continue on to post-secondary education is perhaps the best way of improving overall health for individuals and our society as a whole.
- Many of us know some of the basics of what we should do to stay healthy, but too few people take action. Better incentives may be needed to encourage people to stay healthy.
- People are often confused by a constant barrage of conflicting information about what's good for us and what isn't.
- Compared with the big ticket items like hospital care and diagnostic tests, very little is spent on health promotion and disease and injury prevention.

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Organizing and delivering health services

To many people, the health system is like a maze. It's sometimes difficult to figure out who does what, who's responsible for what decisions, and who is accountable. The Council addressed many of these questions in its context paper on *How does Alberta's health system work?*

Regional health authorities provide better integration but there are challenges.

Alberta's health system was restructured in 1995 with the creation of regional health authorities. At the outset, it's important to say that regional health authorities have done a commendable job of integrating and organizing health services for people in their regions. They are led by committed and dedicated people who believe strongly in the importance of health care and work hard to meet community needs. There is much better integration of the full range of health services from hospital care to home care, long term care, and promotion and prevention activities, and an ability to shift resources to priority areas. But the system is not without its challenges.

- Regional health authorities have little, if any, control over the resources they have available. The majority of their funding comes from the province. And regional health boards spend a great deal of their time lobbying the provincial government for increased funding.
- Physicians drive many of the costs in the health system because of the tests they order, surgeries they do, and the treatments or medications they prescribe. This affects regional health authorities' budgets but they have no control over these costs.
- There is little sharing of expertise, programs and services across the regions.
- There are a variety of political influences involved in decisions made by regional health authorities.
- With newly elected members of regional health authorities, accountability and relationships among board members and with government will be more complex.
- Regional health authorities are often caught between government and health providers. Health providers urge health authorities to make certain changes, but regional health authorities have little ability to respond, especially when funding is restricted.
- Managers in the health system spend too much time "fighting fires" and dealing with crises and have little time to plan ahead, explore innovative approaches, or assess whether certain programs are working or not.
- While there is better integration of many health services, mental health continues to be an exception. Many people suggest that the separation of mental health services from regional health authorities has meant that community programs are limited.
- Alberta's Auditor General has raised concerns about accountability, governance and management in regional health authorities and pointed to weaknesses in business planning and budgeting and gaps in performance reporting.

Access is the number one concern.

Perhaps the single most important issue for Albertans is access. We've tried different ways of organizing and delivering services and invested more money, but the bottom line is, we still have to wait in line for many of the services we need. Sometimes the waits are short, especially when there is an urgent need, but too often, the waiting times are too long.

Most recent information for Alberta shows that:

- waiting times for access to radiology for certain cancers (breast and prostate cancers) have increased to between 2 and 6.5 weeks for breast cancer and between 7 and 9.5 weeks for prostate cancer. Waiting times for chemotherapy range from 4.5 to 10 weeks.
- The number of people waiting for open heart surgery went down by 2.5% between March 2000 and March 2001. The number of surgeries done in the province went up by 8%. Waiting times ranged from 11 days for urgent inpatients to 15 - 18 weeks for planned outpatients. Aside from urgent cases, the waiting times are longer than targets set by the province.
- The number of hip and joint replacements has gone up by 7% between March 2000 and March 2001, but the number of people waiting for those surgeries has gone up by 33%. So people wait an average of two to six months, and for some people, the wait is much longer.
- We've all seen the television pictures of people lined up in emergency waiting for admission to hospital. In Alberta's two biggest regions, Capital Health and the Calgary Health Region, people wait an average of 7.2 hours and 4.3 hours in emergency before they're admitted.
- In some cases, people have trouble accessing a family physician and may have to wait weeks or months to see a specialist.
- In 2000/01, there was a 53% increase in the number of MRIs performed. In March 2001, average waiting times for an MRI were 2 to 16 weeks, depending on the urgency of the problem.

(For more information on waiting times, check the Council's context paper on *How long do people wait?*)

Council has also learned that waiting lists themselves are complex and not comparable from one region to another. People may wait extended periods of time because they are waiting for a particular physician when they could get quicker access to another physician. Stories abound about people who are able to get around the waiting list with the help of their physician or because they know how the system works. Places like Sweden have put in place a system where waiting times for major procedures are posted daily on a website. People can check the website and choose to go to the hospital with the shortest waiting times as long as they are prepared to travel and to use the next available physician. In Alberta, most people are confused by waiting lists and have no choice but to wait their turn.

Clearly, if there is one thing Albertans should be able to expect from their health system it is access to health care services when they need them. Access should be available to everyone on equitable terms. That's the heart of what we expect from our health system, but too often, it's not what Albertans get, in spite of significant and growing investments.

"If there is one thing Albertans should be able to expect from their health system it is access to health care services when they need them."

Mental health is not well integrated with the health system.

Council heard from a number of groups and organizations involved in mental health. A number of serious concerns were noted.

"There is currently no framework for an integrated, coordinated and comprehensive system of mental health services for children, adolescents and their families, either at a provincial or a regional level."

CASA
(Children and Adolescent Services Association)

- **The need for leadership and public education** - The stigma of "mental illness" continues and compounds the burden on individuals and their families. More needs to be done to remove the stigma and anticipate growing needs for mental health services. Studies suggest growing trends of depression, stress, and problems associated with an increasing pace of life. Geriatric services are under-developed and mental health services for children and adolescents are lacking. More needs to be done to set priorities and plan for future mental health care needs.

- **Fragmentation and lack of integration with the health system** - Currently, mental health services are primarily the responsibility of the Alberta Mental Health Board. Some arrangements are in place with regional health authorities but mental health services are not within their mandate. As a result, mental health services are not integrated with other health services available in regions. Many people suggest that this causes problems in the delivery of services in communities, that communities are under-served, and that communication between the Alberta Mental Health Board and the regions is problematic. Many suggest that it's time for mental health services to be transferred to regional health authorities so that integration can be improved, ideas like a single point of entry can be implemented, and regions can be more accountable for meeting mental health needs of people in their region.

- **Inadequate community programs and resources** - The majority of people with mental health problems can be served in community programs and do not require hospitalization. But currently, there aren't sufficient resources available in communities. In addition, there is a shortage of hospital beds to serve people with mental health problems, especially in rural areas. Hospital services in Alberta Hospital Ponoka and Alberta Hospital Edmonton are not well coordinated with regional health authorities and are not adequate for serving southern Alberta.

- **The need for better access to services for children and adolescents** - It's only recently that children and adolescents have been viewed as needing mental health services. Yet studies suggest that 20% of all children and adolescents require mental health services. Children and adolescents with mental health disorders consume a disproportionate share of resources and services in the health system, criminal justice system, schools and social service agencies. In the past few years, a higher priority has been placed on children's mental health but there continue to be delays of up to six months in accessing services for children.

- **Anticipated shortages of mental health care practitioners** - Like other areas of the health workforce, shortages of mental health care practitioners are a reality and will increase with an aging workforce. Staffing shortages are particularly acute in rural Alberta. Combined with that, recruitment of psychiatrists is a problem. And there is a shortage of people trained to work specifically with children and adolescents, seniors, and people with specific needs including Aboriginal people and immigrants.

The health system is a monopoly.

Alberta's health system, like other systems across the country, operates as an unregulated monopoly. Government ...

- Defines what constitutes "medically necessary services"
- Pays for all insured services provided
- Provides insurance and forbids, by law, the provision of private insurance for these services
- Prevents, by law, people from obtaining insured services outside the public system except where there are contracts with the public system
- Directly or indirectly administers and governs care
- Defines, collects and reviews information on its own performance.

In short, it's a command and control system. People have no choice but to get the health services they need from the publicly insured system, and wait their turn in line. The system is organized by government, paid for by government, insured by government, and evaluated by government. Regional health authorities have an important role to play in delivering health services but their budgets are almost completely determined by government, the expectations are set by government, and they are accountable to government. They have too little real authority and they have few, if any, options if they are unable to meet their residents' health needs within existing resources.

In almost every other public and private area, monopolies are simply not accepted. With banks and other financial institutions, retail stores, bookstores, dentists, optometrists or chiropractors, Canadians and Albertans understand and support competition, and we're reluctant to accept a situation where we have only one choice. In education, people have choices about what college, university or technical institute they attend.

Parents can choose which school they want their children to attend - public or private, bilingual, immersion or straight English, and a whole range of specialized programs are available. Schools and post-secondary institutions compete for students, introduce new programs to attract more students, and publish their results. The education system has developed into a customer/student oriented system.

In the public health system, none of this happens. We can choose our own family physician, but frequently, that's where the choices end. We go to specialists referred by our family physicians, get tests suggested by a physician, go to physiotherapy if it's prescribed, take the medications our doctor prescribes, go to the hospital we're directed to, and wait in line if the services we need are not immediately available.

What's the problem with this kind of a system?

- There are no choices. The health system does not encourage people to stay healthy and economize on their use of the health system.
- There's no competition and no incentive to provide the most efficient and effective services available. Health authorities are expected to live within a budget, but they don't control many of the costs and they have few, if any, options if they don't have the resources they need. The result is services are rationed.
- The system is organized around facilities and providers, not individual Albertans. "Customer satisfaction" is important to health authorities, but if individuals are not satisfied, there's no option. They can't "take their business elsewhere" so there is no incentive to keep improving service unless it is to save money.
- In spite of significant investments in the past few years, waiting times for selected services continue to be too long and people worry that the health system may not be there when they need it.
- The old "command and control" central planning approach doesn't work.

- We have only limited information about what actually happens in the health system - what results are achieved, whether new treatments achieve the expected outcomes, or whether new ways of delivering services reduce costs and improve efficiency. In large part, that's because there is a serious under-investment in information technology, so the systems simply aren't in place to collect, analyze and compare results.

Alberta is not alone. The recent interim report of the Standing Senate Committee on Social Affairs, Science and Technology, chaired by the Honourable Michael Kirby, makes a number of compelling statements about Canada's health system - statements that apply to Alberta's system as well.

In their words, health care "is structured like a 19th century cottage industry rather than a 21st century service industry." [1]

The Council consistently heard that there is a need to open up the system and try different ways of delivering services. In the past, this has been done primarily through pilot projects. A number of these pilot projects have been very successful. But the overriding concern is that pilot projects have been burdened with uncertain funding, high administrative costs, and a heavy emphasis on evaluation. As a result, too many pilot projects simply end because there is no further funding available. People get worn down by the administration and evaluation burden. And the pilots don't result in any fundamental change across the system.

Primary health care reform is a solution - but changes move slowly.

Primary health care is a "prime" example of how difficult it is to make major changes in health, even when people agree it's the right thing to do. Federal and provincial ministers across Canada have agreed that primary health care reform is critical. That view is echoed in a number of other reports across Canada and here in Alberta.

A comprehensive approach to primary health care is what many people see as the future direction for community-based health services. It refers to people's first point of contact with the health system. Instead of going to a family physician then getting referred to a series of other health providers, in comprehensive primary health care models, multidisciplinary teams of people work together to provide the services people need. That might include a family doctor, nurse or nurse practitioner, dietician, counsellor, mental health worker, social worker, and others working together. This is clearly the approach Albertans have said they want through a number of province-wide consultations. And yet, the closest we have come is a number of pilot projects. There continue to be barriers to this approach and progress has been slow.

[1] The Health of Canadians - The Federal Role, Volume Four: Issues and Options. Interim Report of the Standing Senate Committee on Social Affairs, Science and Technology. P. xiii

The private sector has a role to play.

Today, most health services are provided in the public sector. In fact, medically insured services cannot be provided in the private sector unless they are publicly funded and provided through a contractual arrangement with a health authority.

Unfortunately, whenever the private sector and health are mentioned in the same breath, the immediate concern is with two tiered or American style health care. The Council believes it is time to lay this particular shibboleth to rest. People assume that private delivery of health care services violates the Canada Health Act. In fact, the Canada Health Act only says that physician and hospital services must be publicly funded and publicly administered. They can be delivered in the private sector, and they often are. Physicians, in fact, operate primarily in the private sector - most own and operate their own corporations while the minority work under contract with health authorities, hospitals and universities. Health services that are not insured such as dental care, some chiropractic services, acupuncture, cosmetic or some elective surgeries are provided in the private system but must be paid for by the individuals who use the services.

Opportunities to expand the type of health care services that could be provided in the private sector meet with heated debates even when the services would be provided through a contract with a regional health authority. The Council has listened, at great length, to both sides of this debate. On the one hand, we understand the arguments about comparable costs in the private sector, the potential impact on the public system if private facilities can "skim off the easy cases" or physicians and other health providers leave the public system to work in private facilities, and the negative impact if people with money are allowed to "jump the queue" to get quicker access to health services. On the other hand, the public system is being stretched to the limit. There are few centres of specialization and little, if any, choice for individuals or health authorities. There are few incentives to be innovative and try new approaches if public facilities have a "captive market." Furthermore, many of those who advocate for an expanded role for the private sector support the primary importance of the public sector, believe physicians should be required to work in the public system as well, and see private sector options more as a "safety valve" to take pressure off the public system.

Options and alternatives

The following are some of the ideas and options suggested to and considered by the Council.

- **Reduce the number of regional health authorities and clarify their role.**

  Alberta has seventeen regional health authorities and many people suggest this is too many for the size of Alberta's population. At the same time, changing regional health boundaries is no simple task. Several reviews have been held and only small changes have been made. While reducing the number of boards may streamline administration and achieve greater efficiencies, the cost savings may be small because the amount spent on administration is relatively small even in the largest health regions. Suggestions have also been made that "bigger is not necessarily better." The challenge is to find a better framework and better incentives for health authorities to work together, share expertise, share services and save money.

"The debate will not be one of whether private delivery should exist, but rather how society can make the most efficient and effective use of the private and public facilities that make up the entire health care delivery system."

Turning the Tide, A Discussion Paper by BC's Physicians

- **Expand comprehensive models of primary health care.**

  There are numerous barriers to comprehensive primary health care, not the least of which is the fact that the majority of physicians are paid on a fee for service basis (i.e. their incomes are based on fees paid for every service they perform). There is no mechanism in place for paying for the additional services of others on the team including nurse practitioners, dieticians, social workers and counsellors. These and other barriers to primary health care reform should be addressed and removed.

- **Introduce new comprehensive care or disease management models.**

  Many people suffer from chronic health conditions such as heart disease, diabetes, or asthma. Currently, there are few mechanisms in place to help people manage these conditions effectively. They can visit their physician for regular check-ups, but there are few models in place for providing comprehensive care and improving the overall health of people with these conditions. For example, in the current system, a patient with a severe heart disease might be seen monthly by the family physician and on several occasions yearly by a cardiologist, and still utilize the emergency department of a hospital on several occasions. There is now evidence to suggest that such a patient would experience better health outcomes if his or her care were managed in a multi-disciplinary program. This patient may require a total of 12 visits - two with a family physician, one with a cardiologist, four with a nurse or nurse practitioner to monitor health status, two with a nutrition counsellor and three with other providers, perhaps to monitor stress or establish an appropriate exercise program. With the current system, the visits to the family physician and cardiologist would be paid for on a fee for service basis, but there is no mechanism for paying for the other services - services that can be very effective in maintaining and improving the patient's health. A comprehensive approach, similar a primary health care approach, would provide a better option for many patients with chronic diseases and help improve outcomes.

- **Unbundle the system and introduce more choice and competition.**

  Rather than have government act as the insurer, provider and evaluator of health services, the various functions could be broken up. The role of government could focus more on setting overall direction and allocating funding to health authorities. The role of health authorities could focus more on providing services, either directly or through service agreements with public and private sector providers and other regions. Rather than limiting the choices available, physicians and groups of health care providers could be encouraged to set up health care businesses, enter the market and compete for contracts with health authorities or market their services to individual Albertans. In places like Sweden, steps are being taken to encourage competition and provide

more choice. Most hospitals continue to be owned by local councils, but they operate with a separate board and have contracts with the council. In one case, a hospital has been sold to a private company that now owns and operates the hospital under contract with the local council. Existing union agreements continue to be in place and their labour leaders have been supportive of the move.

- **Expand options in the private sector.**

  Alberta now has legislation in place that sets the ground rules for contracts between regional health authorities and private sector organizations for delivering certain health services. Facilities and treatments must be approved by the College of Physicians and Surgeons. With clear standards in place, it's time to consider what role the private sector can play in complementing health services available in the public sector, improving access, and encouraging centres of specialization.

- **Improve integration of mental health and other health services.**

  Mental health services are not well coordinated with other health services in communities and many suggest that community mental health services are sorely lacking. Suggestions have been made to transfer responsibility for mental health services from the Alberta Mental Health Board to regional health authorities. Alberta Hospital Ponoka, Alberta Hospital Edmonton, and other facilities could also be transferred to regions and services could be provided to the rest of the province in a similar way as province-wide services now are provided by the Calgary Health Region and Capital Health Authority. On the other hand, some have expressed concerns that this could result in lower priority for mental health issues. They feel that the Alberta Mental Health Board, with a province-wide mandate, is in a better position to provide leadership, work with regional health authorities, provide public education, and expand mental health services.

"As long as they are contracted to provide medically-necessary services through public health ministries ... and as long as they are constrained from using public funds to subsidize queue-jumping, private innovators could do wonders for our health care system."

Southam News Editorial, Edmonton Journal December 13, 2001

In summary ...

- Alberta's health system is a monopoly where government is the insurer, provider and evaluator. The disadvantage is there is little choice and competition in the system.
- If we're going to have regional health authorities - and we should - then it's time to give them the mandate and the tools to allow them to do the job and hold them accountable if they don't.
- Users of the system should have more control, more choice and more accountability.
- We need to open up the system, take off the shackles, refine or eliminate some of the rules, and try new ideas.
- If there is one thing Albertans should be able to expect from their health system it is access to health care services when they need them. Access should be available to everyone on equitable terms. That's the heart of what we expect from our health system, but too often, it's not what Albertans get, in spite of significant and growing investments.
- We need to seriously look at expanding the role of the private sector in delivering insured health services.
- A number of options are possible for changing the way health services are organized and delivered. The system should be opened up so a number of these options can be implemented without the onerous burden of administration that has characterized pilot projects in the past.
- Serious problems in mental health need to be addressed.

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Paying for health services

"We know what we want.
We just need to find a better way to pay for it."

In many ways, that's the key challenge. There's no shortage of good ideas in health. Doctors, nurses, health administrators and a whole bunch of people have good ideas about how we can deliver health services in a better way. But the challenge frequently comes down to "How do we pay for it?"

Let's start with the facts.

Trends show increased spending on health.

- Health spending in Alberta has increased from $3.9 billion in 1995/96 to over $6.4 billion in 2001/02 - a 64% increase. If you add in capital costs, the total is over $7 billion. If we look at the past ten years and compare total spending on health in 1991-92 to total spending in the budget for 2001-02, spending has increased from just over $4.1 billion to over $7.1 billion today, an increase of over $3 billion.[2]
- In 2001/2002 Alberta spends about $20M per day on health care. On a real per capita basis, spending on health dropped in the mid-1990s but has steadily increased since 1995-96.
- As a percentage of provincial program expenditures in 1990/1991 Alberta spent 24% on health and 76% on all other government programs. In 2000/2001, about a third was spent on health and 65% on all other government programs.
- Alberta has a volatile economy, heavily dependent on the price of oil and gas. If those prices level off or decline, it will be difficult to maintain current spending, let alone afford increasing costs in the future.[3]
- Based on current trends, spending on health could take up half of all program spending by 2008.
- Inter-provincial comparisons of spending from 1986 to 2000 show that Alberta's spending is comparable with other provinces.
- While Alberta's spending dipped below the Canadian average in 1993, it climbed back above the national average in the last year.
- Overall provincial/territorial government expenditures on health have increased substantially over the past two decades - from about $11 billion in 1977/78 to almost $56 billion in 10 years. The combination of cost drivers and cost accelerators could see national spending exceed $100 billion per year in 10 years.
- Drug costs are expected to grow substantially over the next decade. Across the country, drug costs are expected to rise from $4 billion today to over $15 billion by 2026/27, almost a fourfold increase.[4] At the same time, drugs have had a significant impact on treating illnesses, reducing the need for certain surgeries, and improving quality of life.

(For more information on trends in health spending, check the Council's context paper *Is Alberta's health system sustainable?*)

[2] *The Future - Meeting Priorities, Sharing Benefits*, Budget 2001 Fiscal Plan, Province of Alberta, p. 58
[3] Current budget was based on $5/mcf for natural gas. At the time of preparing this report, the price was under $3/mcf. Each 10 cent decline means a reduction of $142M in provincial revenues. For oil, the budget was based on US$25 a barrel. In recent weeks, the price of oil has dropped below $20 a barrel. A $1 drop in the price of oil means a $153 million reduction in provincial revenues.
[4] *Understanding Canada's Health Care Costs*. Provincial and Territorial Ministers of Health. August 2000.

Health care costs will continue to rise.

The Provincial and Territorial Ministers of Health did an excellent job of categorizing factors that are expected to contribute to increasing health care costs. In their report, *Understanding Canada's Health Care Costs*, they divide the factors into three categories:

- **basic cost drivers** - including population and aging, inflation and rising costs of labour and facilities
- **cost accelerators** - including emerging and new technologies, new drugs and genetically-specific drugs, increased incidence of chronic and new diseases, declining productivity gains, and rising consumer expectations. Genetic research, for example, has the potential to uncover many of the underlying molecular causes of certain illnesses, but the research is expensive and the treatments will be as well.
- **the impact of system change and reform** - including structural changes, changes in how services are delivered, the scope of services provided, roles of providers, information systems, research and continuous improvements in the quality of health services.

Without getting into detail about the impact of cost drivers on Alberta's system, it's fair to say that:

- costs will continue to increase in spite of cost containment efforts by health authorities and governments
- population growth and aging will have an impact on increasing costs and that will be compounded by increasing costs of new technology, new treatments, new drugs, new equipment, and rising expectations
- shortages of trained staff in all aspects of the health system will strain existing resources and make it difficult to deliver the services people want and expect
- changes in how the system operates are long overdue, but will not necessarily result in cost savings - for example, comprehensive primary health care may cost more to implement, expansion of home care saves costs in hospitals but increases costs for nursing and other care in the home, and integrating mental health services into communities is critical, but will increase costs.

(For additional information, check the Council's context paper on *What factors drive costs in health care?*)

Without changes, spending on health care is not sustainable.

In the face of this information, what can we conclude? Is Alberta's health system sustainable the way it is financed today? Based on the evidence we've heard about current trends and various factors driving costs, the answer is almost certainly no.

- **We can only afford to spend more on health if Alberta's economy grows faster than spending.**

  Spending on health has increased by an average of 10% a year since 1996. That's much faster than the growth in our economy. We can only afford the current level of spending if our economy remains strong and prices of oil and gas stay high. We've seen the impact of recent international events on the province's financial picture. Declining prices for oil and gas are having an immediate impact on our ability to pay for current costs in health let alone sustain the system over time.

"For each additional dollar that we choose to allocate to health care, there is one less dollar for education, social services, debt reduction and other important public initiatives."

The Future Cost of Health Care in Canada, Conference Board of Canada, 2001

- **Health spending could soon take up half of all spending on government programs.**

  Based on current trends, spending on health could take up half of all government spending on programs by 2008. The question becomes: Are Albertans willing to devote half of all government spending to health? What does this mean for other essential services like education, infrastructure, environmental protection, or security?

- **Costs in health are growing dramatically.**

  We've seen a number of factors that are driving increasing costs in health - population and aging, inflation and cost increases, new treatments and technology, even new ways of delivering health services all result in higher costs. Combined with that, health care is a people-intensive system. Labour costs make up about 75% of spending in health. In 2001-02, more than half of the budget increase for health - $390 million - went to salary increases. Those costs will continue to grow, particularly because Alberta is in a national and international race to recruit and retain health providers.

- **We pay for health on a pay-as-you-go basis.**

  There is no long term planning for future costs in health care. Instead, we pay for health care costs on an annual basis. Health authorities are given three year budget targets, but those targets have been subject to frequent adjustments so stability is lacking. We also know that future costs will be higher because of a number of other factors driving costs. But we are doing nothing to set aside funds now to pay for higher costs in the future. This means health funding is heavily dependent on annual revenues to the province and can fluctuate significantly as the price of oil and gas swings up or down.

- **Albertans' expectations for health care are growing.**

  Whenever there are new treatments or technologies, Albertans want access to them. We want and expect quick access to the services we need, when we need them. Access to health care services and waiting times are people's number one concern with the health system. With more information about new treatments and possibilities, people's expectations grow. Not surprisingly, there is a constant battle between people's growing expectations and the reality of increasing costs and limited budgets.

Again, Alberta is not alone. Together, the provincial and territorial Ministers of Health agreed that, "Canadians continue to be well served by their health care system, but it is under serious challenges due to rising demand and cost structures."[1]

More money doesn't necessarily buy better health.

If Albertans were to decide to just keep spending more on the province's health care system, would this buy better health or better health care outcomes?

Various studies and international comparisons suggest that, above a certain amount of basic funding, there is no direct relationship between spending on health care services and the overall health of the population. The United States spends considerably more than other countries on health as a percentage of its Gross Domestic Product (GDP) but health outcomes such as life expectancy, maternal mortality or infant mortality are poorer than countries that spend less including Canada, Japan or Sweden. More money, if it is not used effectively or in combination with other reforms, will not necessarily result in better health outcomes.

(For more information, check the Council's context paper on *Is Alberta's health system sustainable?*)

[1] *Understanding Canada's Health Care Costs*, Final Report. Provincial and Territorial Ministers of Health, August 2000. Page 57.

Health care is considered a cost, not a driver of Alberta's economy.

Because the majority of funding for health care comes from provincial budgets, health care is almost always viewed as a cost - sometimes even a tremendous burden on the provincial budget. At the same time, health care is a huge industry in the province. Thousands of doctors, nurses and other health providers earn good incomes and contribute significantly to Alberta's economy. Our reputation as a leading medical research centre attracts some of the best and brightest physicians and researchers to the province and helps build Alberta's potential in a knowledge-based economy. From purchasing equipment and supplies, to building new facilities, hiring contract workers, and employing thousands of support workers, health authorities in the province are a major player in Alberta's economy. While we view increased spending in other sectors as a positive sign in Alberta's economy, we see increased spending in health almost exclusively as a threat to future stability in provincial budgets.

Options and alternatives

What is the answer? Is it simply to spend more from the taxpayers' pockets or keep rationing services to meet the reality of fixed budgets? Here are some of the ideas and options considered by the Council.

- **Decide how much of the provincial budget will be spent on health and stick to it.**

  If we agree that provincial spending on health cannot be allowed to increase with no limits and to the extent that it crowds out other important functions, then one option would be to set an arbitrary limit on how much the province could spend on health care and how much spending could increase over time.

  This approach would limit the supply of health services to a set amount that's affordable within the total budget amount. It would not address the question of increasing demand and costs of services that exceed the budget available.

  If we assume that increasing demands and costs will continue to outstrip growth in the province's economy, the most likely result would be continued rationing of health care services. And that begs the question: How long are Albertans prepared to wait? How long will they be prepared to accept the fact that new health treatments and technology may be available but they can't access them because it's not affordable through provincial budgets?

- **Work with health authorities to seek efficiencies and reduce costs.**

  Health authorities face a constant challenge of trying to meet increasing demands and rising costs with limited budgets. The Council consistently heard from health authorities that there are steps they can and will continue to take to reduce costs. But the amount they can save would be limited in comparison to increasing costs for labour, technology, new treatments, tests and pharmaceuticals, many of which are beyond their control. More work needs to be done to extract maximum value from every dollar spent in health care and to ensure we are getting the best outcomes for the money that's spent. But even with the most optimistic view, it almost certainly will not be sufficient to accommodate increasing demands and costs that go well beyond the economies we can find in the existing system.

"Through the Internet, the new consumers have access to timely research on the newest innovations and advancements in health care and expect these best services for both themselves and their families. People no longer want the health system to develop basic services but now expect to have all of the options, all of the time, wherever they live."

Understanding Canada's Health Care Costs, Provincial and Territorial Ministers of Health, 2000

"... the fundamental flaw of the medicare system is that patients bear no direct costs for the medical services they receive."

David Gratzer, Code Blue

"No health system can meet all those needs, even in rich countries. So either there must be conscious choices of what services should have priority or the services actually delivered may bear little relation to any reasonable criterion of what is most important."

World Health Report, 2000

- **Consider new sources of revenues.**

Under this option, government would continue to provide the majority of funding to the health system and increase funding at a reasonable rate every year. But the combination of federal and provincial budgets would not be the sole source of funding for health care. Additional revenue could be raised through a number of options including medical savings accounts, increased health care premiums, user fees, co-payments, deductibles, taxable benefits, or supplementary insurance. Some have suggested regional health authorities should be able to generate additional funds through a number of options such as charging full costs for services that are not medically insured, charging for services like restaurant inspections or environmental assessments, or allowing health authorities to tax their local residents. Others have suggested increasing charges for patients from other provinces or establishing a new health lottery fund.

Suggestions also have been made that regional health authorities should be allowed to raise additional revenues through plebiscites in their communities. Rather than tying additional funding to the property tax base, residents could be charged a flat fee to support health care services in their region. To avoid serious inequities among regions, a fee could only be charged to residents not to businesses or industry. If regional health authorities want to raise supplementary revenues for particular projects or facilities, they could do that through a plebiscite. In addition, if regional health authorities faced deficits, they would be required to go to their community members with a plebiscite rather than approaching the province for additional revenues. While there are downsides to this approach, on the positive side, it would make regions more accountable to their community members, allow regions to be more responsive to their communities' health needs, and also allow community members the option of paying more for additional or specialized services.

- **Limit health services that are publicly insured.**

When the Canada Health Act was introduced, it was never designed to cover the full range of health care services now available. In fact, it only requires public coverage for most physician and hospital services. But all provinces have added to the range of health services that are publicly funded. And many people have come to believe that all health services are or should be publicly insured and universally available at no cost to the individual.

In Alberta, "insured services" refers to medically necessary physician services, dental-surgical services, hospital services and insured surgical services provided at designated surgical facilities. In addition to basic medical services, Alberta provides support for home care benefits, physical therapy and community rehabilitation services. Alberta supports podiatry and chiropractic services while some other provinces do not. Contrary to what some people may believe, across Canada, there is considerable variation in terms of which services are publicly insured and which are not.

Under the Alberta Health Care Insurance Plan, three types of health benefit programs are provided:

- basic health services (includes medical, oral surgery, optometric, podiatric, and chiropractic benefits but only the medical and oral surgery are considered insured services)
- extended health benefits (includes optical and dental goods and services and services provided to seniors, widows and their dependents)
- Blue Cross (provides supplementary health benefits to seniors and other individuals including coverage for prescription drugs).

Medical benefits are the largest component of the Alberta Health Care Insurance Plan. Services that are covered are listed under the Schedule of

Medical Benefits. The Alberta Medical Association is involved in any decisions about adding or deleting services to the schedule of medical benefits.

Over the years, many new treatments and technologies have been added to the list of insured services. Generally, decisions involve assessment of the technology, analysis of the impact, expert consultations, government review, development of legislation if necessary, review by the Legislature or government, and implementation. Specific processes are in place for making decisions about new drugs to be covered and new province-wide services (highly technical services provided only at the Calgary Health Region and the Capital Health Authority). Ultimately, the decision about whether a health program or specific service, drug or procedure will be funded is made by the Minister of Health and Wellness or collectively by the government.

It's fair to expect increasing pressure to add more treatments, programs and drugs to the list of insured services. If that happens, can or should we put any limits on what gets covered and what doesn't? How should those decisions be made? Is it reasonable to drop some procedures off the list as new, more complex, and more effective treatments are discovered?

"When it comes to health care, Canada can no longer afford to be all things to all people. Some hard choices need to be made. These choices will undoubtedly alter the face of medicare as we know it, but they do not have to be choices which will destroy the public program. On the contrary, they must be choices which ensure that the program is placed on a stable footing for the future, so that it will be there for everyone, when they need it."

Turning the Tide,
A Discussion Paper
by BC's Physicians

In summary ...

- The continuing escalation of health care costs without a clear funding plan and the consequent impact on federal and provincial treasuries creates an unstable climate and affects the confidence and performance of the health care system.
- If we approach the issue of sustainability as solely a cost containment and rationing exercise, we're doomed to failure. Albertans want timely access to a full range of health services and they're increasingly willing to consider other options in order to get the kind of access they want.
- Instead of saying these new treatments and technologies are available somewhere but we can not afford them so you can not have them, we need to find new ways of providing the services that people want and need, and we need to find new ways to pay for them. Only in this way can we expand opportunities, improve access, secure sustainability and improve health.
- Demands for health care will increase and cost more ... not because people use the health system frivolously or that people who run the health system are unable to do a good job of managing their budgets ... but because we're on a relentless pursuit of new knowledge, new treatments and new cures to save lives and keep people healthy.
- Mechanisms must be in place to ensure maximum value for spending is achieved. We can restructure, streamline, improve efficiency and introduce some competition in the system to ensure we get better value and contain costs. But those measures alone will not be sufficient to match increasing demands and costs in the health care system.
- Circumstances in Alberta and elsewhere in North America are such that the overall tax burden cannot be expected to rise to match increasing costs in health care. Instead of relying almost exclusively on the tax base, we need to diversify the revenue stream to support the health care services people want and expect.
- Spending on health care cannot be allowed to crowd out other vital forms of public spending, including education, infrastructure and other social services. Our future prosperity and health depend on all of these, and to the extent that it is crowding out these other forms of spending, tax-financed health care in its current form is not sustainable.
- The scope of publicly funded services should be more clearly defined and reviewed on a regular basis.

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Ensuring an adequate supply and best use of health providers

"The most pressing immediate factor limiting the ability of health authorities to bring new service capacity and programs on line in response to public demand for access to services is availability of qualified nurses and technical/ professional personnel."

Council of Chairs of Regional Health Authorities and Provincial Boards

Sustaining Alberta's health system requires more than money. We need to ensure that Alberta has enough doctors, nurses and other health providers to deliver the health services we need.

We hear regular reports about a looming crisis in attracting and keeping an adequate supply of doctors, nurses, technicians, pharmacists and a whole range of health providers. There are many stories of doctors and nurses heading to the United States for better pay and better working conditions. In certain parts of the province, health authorities have serious difficulties attracting and keeping physicians and hiring nurses.

Alberta is not alone in facing these challenges. Other provinces and states in the U.S. are also having trouble finding and retaining health care providers. Actions in Alberta to increase salaries and establish other incentives are attracting some physicians and nurses from other provinces, but this has a negative impact on those provinces and their efforts to retain the doctors and nurses they need.

The following provides some highlights about what we have learned about the shortage of health providers, factors that affect the ability of health authorities to attract and keep health providers, and ways of making the best use of the full range of health providers.

Shortages are looming for many health providers.

In many cases, good information is not available on actual shortages of various health providers. But based on the best information available, there is no doubt that Alberta is facing significant shortages of a wide variety of health providers.

For physicians, shortages are a serious problem in communities across the country. While smaller, rural communities have faced these challenges for many years, major urban centres now are also having difficulties attracting a sufficient number of physicians especially in some specialties. Estimates are that Alberta may need an additional 1,329 physicians by 2004/05. The number of physicians who choose to stay in Alberta following graduation is increasing and fewer physicians are leaving Alberta to practice abroad. Decisions made by the provincial government in January 2001 will increase medical school enrolments. However, in spite of these actions, it is likely we will face serious shortages of physicians.

The situation for nurses is even more serious. While good information on vacancies for RNs is not available, regional health authorities indicate that there is a shortage of about 1950 nurses for 2001/02. This trend is expected to continue for the next three years, which means Alberta could be short 6000 nurses by 2003/04. Alberta's nursing workforce is also aging; the average age of nurses is 43.4 years and close to 30% of them are over 50. More than 25% of the nursing workforce is slated for retirement in the next decade. Surveys indicate that close to 70% of Alberta nurses expect to be in nursing a year from now but only half expect to be in nursing in five years. Actions are being taken to expand enrolments in nursing programs and shorten the time it takes to complete a bachelor of nursing program.

Similar shortages are anticipated for a number of other health providers including pharmacists, mental health practitioners, rehabilitation practitioners, technicians, and laboratory technologists.

For those who have worked in the health system for many years, the pattern has been regular peaks and valleys where the supply of health providers is out of sync with the demand. It seems to be tied to either an abundance or shortage of funding for the health care system. When funding is limited, jobs are limited and fewer people choose to enter training programs thinking there will be few job opportunities available for them. This results in an under-supply. Conversely, when funding is abundant, jobs are readily available and more people choose to enter the profession. The result is an over-supply.

While it is difficult to predict future supply and demand of health providers, many suggest we should be able to do a better job of preparing integrated health workforce plans and anticipating future needs.

(For more information, check the Council's context paper on *Do we have a shortage of health professionals?*)

We can make better use of the full range of health providers.

There is a wide and diverse range of health providers in the province including family practice physicians and specialists, nurses, nurse practitioners, licensed practical nurses, mental health practitioners, pharmacists, medical laboratory technologists, rehabilitation therapists, dentists, dental surgeons, chiropractors, podiatrists, and so on. The list is long and comprehensive.

Under the current system, many health authorities talk about the goal of providing "the right service by the right provider." But the reality is that some services provided by physicians could be provided by nurses, nurse practitioners or pharmacists. Some work done by nurses could be done by licensed practical nurses. There likely also are expanded roles that other providers could play in aspects of health care such as mental health, community programs, or health promotion.

Unfortunately, there are a number of barriers in place. While many of the professional organizations talk positively about the need to work together, in reality, they seem unwilling to give up parts of their "scope of practice" unless there is some corresponding compensation. While some professions are interested in expanding their scope of practice at the "higher" end of more complex services, they are unwilling to give up any services at the lower end where technicians and assistants could perform the work. In some cases, legislation is a barrier; for example, existing legislation limits the use of nurse practitioners except in areas that are under-served by physicians. In other cases, union contracts require the use of particular health providers even though others could probably do the work and at less cost.

Appropriate incentives are not in place.

"Incentives matter. All the rest is commentary."

One of the consistent messages we have heard is that the current incentives for providers in the health system do not support the kind of integrated health care many would like to see.

We are not blaming doctors, nurses and other health providers for the situation. It's not their fault, but the rigid structure for paying these highly valued professionals strongly mitigates against meaningful change, especially in terms of expanding comprehensive primary care and other disease management approaches.

Think about these examples:

- Most physicians are paid on a fee-for-service basis. At the end of March 2001, there were six pilot projects in place for alternative payment plans for physicians with plans for 11 more projects underway. The natural and logical incentive for fee-for-service physicians is to treat more people, order more tests, or perform more procedures. In fact, physicians cannot be paid unless they actually see their patients. So they are forced to encourage repeat visits for things like refilling prescriptions because otherwise they are not paid.

- Many people support the idea of multidisciplinary teams of health providers working together - doctors and nurses, nurse practitioners, dieticians, social workers, etc. And yet, there is no way of paying for it. If a doctor wants to start a clinic and work with a team of other providers, there's literally no way of paying for those services aside from taking it out of his or her own earnings. The best we have is a few pilot projects, and the administrative burden and uncertainty surrounding those projects discourages many people from getting involved.

"Specialists often see patients who could be seen by family doctors or nurses while specially-trained nurses or others could perform much of the day-to-day work of family doctors. However, provincial medicare plans do not allow nurses to bill while doctors cannot bill for independent work done by their nurses, and there are very few interdisciplinary clinics using alternative funding approaches."

Revitalising Medicare: Shared Problems, Public Solutions, Rachlis, Evans, Lewis and Baer, January 2001

"Ten years of downsizing the health care system have only exacerbated the situation by producing unhappy patients, horrific workloads for nurses across the system, destruction of organizational loyalty, and decaying morale among all health care workers. There is no easy fix, and no single strategy will turn the situation around."

Interim Report of the Standing Senate Committee on Social Affairs, Science and Technology, September 2001

- Health providers all have their own "territory." Nurses and doctors say they want to find better ways of working together, but there's no incentive to make it work. So we continue to have a gap between nurses and doctors, very limited use of nurse practitioners, and decreasing use of licensed practical nurses.

There's more to attracting health providers than good incomes.

Council consistently heard that attracting and retaining health providers involves more than paying good salaries. We need to look at the reasons for current dissatisfaction and low morale among health care providers. Health providers feel they are not appreciated and there is little understanding of their expectations and views by those in charge of health regions. Individuals "in the trenches" feel that they are not being heard.

Many health providers feel they have been marginalized and their opinions are not valued. This has a direct impact on efforts to retain nurses, doctors and health providers.

In the case of nurses in particular, working conditions have a negative impact on their willingness to stay in the profession. The number of nurse managers has decreased significantly. Only 39% of Alberta's nurses are working in full-time positions compared with 54% who worked part time. Close to one in three nurses worked on a casual basis in 2000. Many nurses complain about the lack of full time jobs and the requirement to work overtime. At the same time, contract settlements also have an impact on how much nurses are paid for full time vs. casual employment and many can earn as much or more on a casual basis.

Health unions play a powerful role.

Alberta has a number of very powerful unions and professional organizations. The United Nurses of Alberta and the Alberta Medical Association in particular provide not only a strong voice for their members but are actively involved in advocating certain positions that not only affect their members but the health system as a whole. It is understandable that powerful unions and health organizations may have, at times, acted as barriers to change unless they see those changes to be in the best interests of their members. To the public, however, it often seems that those directly involved in leadership positions in the health system can rarely agree on what can or should be done to improve Alberta's health system.

Options and alternatives

Council considered a number of ideas for addressing issues related to both the shortage and best use of health professionals.

- **Openly acknowledge the critical importance of doctors, nurses and other health professionals to the system.**

  Too frequently, when problems with the health system are noted, there's an implication that doctors, nurses and other health providers are to blame. It is important to acknowledge that the full range of health care providers are at the heart of our health system. The quality of care people receive depends directly on their services. Many have been actively involved in trying to find better ways of delivering the services people need and expect. And health providers see first hand the impact of waiting times and the inability to get people the services they need when they need them.

- **Do a better job of planning ahead.**

  Central planning approaches haven't worked well in the past. Decisions to reduce enrolments in medical faculties and nursing programs are now having a serious impact on the near-term shortage of doctors and nurses. Often, projections for the likely numbers of one profession do not take into account changes in the availability or scope of practice of other providers. At the same time, it should be possible to take a more comprehensive look at future needs for various professionals and use that information to guide decisions.

- **Remove barriers to better use of health providers.**

  The provincial government has taken steps to review legislation for health professionals and examine their various scopes of practice. However, professional organizations are going to have to be more willing to give and take rather than simply protecting the "turf" they already have.

- **Address workplace issues that cause dissatisfaction among health providers.**

  Most regional health authorities recognize the problems in their workforce and are taking steps to address them. Examples include providing avenues for doctors, nurses and other providers to be more actively involved in decision-making processes, expanding continuing education, expanding permanent positions for nurses, and increasing the number of front line nursing leaders. Much could be learned from "magnet hospitals" in the U.S. where they have been able to create a work environment that attracts and retains their workforce and, at the same time, also improves outcomes for their patients.

- **Step up actions to attract and retain doctors, nurses and other health providers.**

  Most health authorities are actively involved in programs and initiatives to attract and retain more health providers. These programs need to be tailored to the needs of each region. The province can and does play an active role in supporting initiatives to attract more physicians to rural communities.

  At the same time, Alberta, as a relatively wealthy province, should educate sufficient health personnel to more than meet its own needs and not rely on recruitment from other provinces. This does not imply that movement of health professionals between provinces should be controlled or discouraged.

"We contend that the system has reached the limit of efficiency in the current model and that significant reform is needed to make the best use of all health professionals."

Alberta Association of Registered Nurses

"When the highest paid providers are used to perform a function that other lower paid professionals can perform at less cost, the system incurs unnecessary expense. In Alberta, it is common practice."

Perspectives on Nursing, College of Licensed Practical Nurses of Alberta

In summary ...

- Alberta faces serious shortages of a wide range of health providers.
- Steps have been taken to expand education and training programs, but it will take time before those graduates are able to enter the workforce.
- Current incentives for physicians and other health providers do not encourage or support the kinds of comprehensive care many people would like to see.
- There are few incentives for teams of health providers to work together and provide comprehensive, patient-focused care.
- Professional organizations talk about the need to share expertise, but change has been slow in coming and the result is under-utilization of the full range of health providers, especially nurse practitioners and licensed practical nurses.
- Without getting into a central planning exercise, we need to do a better job of anticipating future demands and changes to the professions, and matching that with capacity in post-secondary education and training programs.
- Serious attention should be paid to factors causing dissatisfaction and low morale in the health workforce. It will take more than money and better salaries to solve these problems.

- **Do a better job of planning ahead.**

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Evaluating outcomes and ensuring continuous improvements in the health system

"Health care is the largest public spending programme in government. Yet we do not possess the information, or even the ability to gather the information, that would allow us to assess the performance of the current system, let alone evaluate the realistic alternatives."

Operating in the Dark: The Gathering Crisis in Canada's Public Health Care System, Crowley, Zitner, and Faraday-Smith

We've all heard the slogan, "Quality is job 1." That slogan should be a hallmark for Alberta's health system instead of a marketing pitch for the Ford Motor Company.

When we talk about quality in health care, what do we mean? In Saskatchewan, Commissioner Kenneth Fyke defined quality in these terms.

> *"Essentially, it boils down to doing the best job possible with the resources available. It means achieving stated goals and targets. It is measurable against accepted and valid standards. It is incompatible with waste, duplication and fragmentation. It is about minimizing underuse, overuse and misuse. It is not about heroic effort or the futile pursuit of the impossible. It is unlikely to be achieved by a demoralized workforce or inadequately trained personnel. It does not thrive where there is conflict or lack of consensus on goals and mission. It is about leadership, goal setting, teamwork, process, measurement, commitment, incentives and accountability."* [6]

With that description in mind, what issues have been raised in relation to quality in Alberta's health system and what steps can and should be taken to ensure better outcomes in health?

Lack of good information is a critical problem.

Compared with the private sector, there is a serious under-investment in information technology in the health system. As a result, basic questions such as how long people wait for a certain procedure in one region compared with other regions or whether certain treatments are having the expected results are difficult, if not impossible, to answer. In addition to under-investment, health authorities are not required to purchase compatible information technology systems, so the result is some regions have information systems that may not allow information to be readily shared and compared with other regions. Some in the health system have said that even when huge amounts of data are collected, it often goes un-analyzed because there isn't the time or the resources. As Commissioner Fyke in Saskatchewan put it, "The health care system is data-rich, and information poor: there is little that tells managers, the public or providers about the quality of their labours in relation to agreed-upon goals and standards."[7]

Evaluation is done by the same people responsible for paying for and providing the service.

We talked earlier about the health system operating as a monopoly. In the case of evaluating outcomes and providing timely information to guide decisions, this is a major stumbling block. Within Alberta Health and Wellness and the regional health authorities, considerable work has been done to collect, analyze, and report on important trends and issues in health. But the fact is, there is no independent, arms length assessment of the outcomes and no external "audit" of the impact of the results. In the face of other priorities, it is easier to under-invest in information technology and analyzing outcomes in health because the public has no choice but to use the public health system, whether it achieves the results we want or not.

Evidence is not used to guide decisions.

The Council's goals stress a health system that is "evidence-based" - a system where the best information is used to guide decisions. Because of the shortage of good information in health, decisions are not necessarily guided by the best information and are instead made for a variety of reasons including past experience, expediency, political influences, or to comply with the wishes of health professionals or other health organizations.

A quality system should put patients first.

In a quality-focused system, the first priority should be ensuring that individuals get the kind of health care services they want and need and are also given the tools and support they need to stay healthy. In Alberta, the health system focuses primarily on hospitals and health providers. People are expected to fit into the system and get service when the system can provide it. In other countries, changes have been made to try to put more focus on the patients. This includes introducing health charters or care guarantees to ensure that people get the care they need within a certain period of time.

Standards and targets are lacking.

When people are told they'll have to wait four weeks for an MRI, how do they know if that's reasonable or not? In all but a few cases, there aren't standards in place that would allow a person to know whether the waiting time is reasonable or not. In the case of physicians, some work has been done to establish clinical practice guidelines that set out "protocols" for treatments that should be required for certain health conditions. However, aside from protecting themselves against legal liability, there is little incentive for physicians to follow clinical practice guidelines even though some suggest this could improve quality of care, reduce the use of unnecessary tests and treatments, and reduce costs. Some have suggested that as much as 30% of current tests and treatments are unnecessary and do not improve health outcomes.[8] In Sweden, physicians are actively involved in compiling "registries" of information on the outcomes of procedures done to treat certain conditions. That information is shared with physicians across the country. No similar processes are in place in Canada or Alberta; instead we rely on isolated research projects.

"Commitment to quality is the only way to get quality."

Commissioner Kenneth Fyke

Continuing investments in research are critical for the longer term future.

Alberta is well known as a Canadian leader in health research. Many exciting breakthroughs have been discovered in Alberta primarily as a result of the support of the Alberta Heritage Foundation for Medical Research (AHFMR). This work is essential and should continue to be supported. In addition to research focused on new treatments and cures, research on the impact of different ways of delivering health services on improving the quality of care should be expanded. There also is a considerable challenge in researching and assessing the impact of new technologies. Before decisions are made on whether to purchase new equipment or change the way people are treated, it is critical to have independent technology assessments. The AHFMR does technology assessment and has the capability of creating a centre of expertise in this area for the prairie provinces.

"Research-based evidence - not tradition, anecdote, or unsubstantiated opinion - should guide practice and resource allocation."

Commissioner Kenneth Fyke

[6] Commissioner Kenneth J. Fyke. *Caring for Medicare - Sustaining a Quality Health System*, Saskatchewan Commission on Medicare. April 2001, p. 44
[7] ibid, p. 45
[8] Berwick, D.M., Blanton, A.B., Roessner, J. *In Curing Health Care. New Strategies for Quality Improvement.* Jossey-Bass Inc. Publishers, 1991.

Options and alternatives

The Council considered a number of options and alternatives for improving quality in Alberta's health system.

- **Set standards, benchmarks and targets and measure results**

While some work has been done in the province to set standards, benchmarks and targets and measure results, this work is not used to drive decisions in health and health authorities and providers are not held accountable for the results they achieve. In short, there are no rewards for better performance and no penalties for poor outcomes. A more public and transparent process of setting targets and reporting on performance may provide more of an incentive for health authorities and providers to improve quality and results.

- **Increase investment in information technology**

Better information can't be achieved without an expanded, long-term investment in information technology. Ideas like an integrated electronic patient record or a form of electronic health card are crucial to any assessments of quality health care and have been talked about for years, but without a firm commitment and investment, they will not happen. Some have suggested that instead of allowing health authorities to develop or purchase their own systems, common standards should be set by the province. Instead of developing new systems for Alberta, some have suggested that information systems have been developed elsewhere (such as private sector companies in the United States or with the banking industry) and the technology could be adapted for use in the Alberta context.

- **Establish arms length responsibility for assessing health outcomes and quality improvements**

Alberta has a Health Services Utilization Commission whose mandate is to "foster continuous improvement in the performance of the health system by informing individuals, providers, funders and other stakeholders about the use of health services and engaging them in positive changes." The Commission is expected to provide leadership in analyzing utilization of the health system, create information, develop conclusions and recommendations, engage stakeholders and the public, and promote and encourage a culture of evaluation and continuous improvement. Unfortunately, ensuring that the health system is utilized appropriately is only one part of a comprehensive approach to ensuring quality in Alberta's health system. In addition, the Commission has only a limited-term mandate while research on quality and outcomes often takes many years to complete and assess.

- **Consider greater use of clinical practice guidelines or "registries" approaches**

Some have suggested that physicians should play a more active role in developing and encouraging wider use of clinical practice guidelines as a way of providing quality care and saving unnecessary procedures and costs. However, work on developing clinical practice guidelines has been slow and there is little incentive for physicians to actually follow the guidelines. A registries approach similar to that used in Sweden may provide an option where physicians are more actively engaged in reviewing data on outcomes for various procedures and adjusting their practices accordingly.

"... priority should be given to electronic patient records, since this kind of system is the cornerstone of an efficient and responsive health care delivery system that is able to improve quality and accountability."

Interim Report of the Standing Senate Committee on Social Affairs, Science and Technology, September 2001

- **Establish an ombudsman for health**

Some have suggested that, because of the complexities of the health system and the difficulty individuals have in judging whether they received quality care or not, an ombudsman for health should be established. Currently, the Alberta Ombudsman does not have jurisdiction to investigate concerns raised by individuals about the health care system. In 1998, a decision was made to expand the mandate of the Alberta Ombudsman to include health authorities and agencies funded by them, however, legislative changes have not yet been implemented. Currently, British Columbia is the only province where professional bodies are subject to the role of the provincial Ombudsman.

Some argue that expanding the role of Alberta's Ombudsman to cover health care complaints would provide people with an independent avenue to have their concerns addressed. On the other hand, others suggest that health authorities already spend considerable time listening to concerns and investigating complaints and it may be preferable to keep this process closer to the communities involved. Complaints about the conduct of health providers can be taken to various professional bodies such as the College of Physicians and Surgeons, the College of Pharmacists or the Alberta Association of Registered Nurses.

In summary ...

- It's difficult, if not impossible, to have an "evidence-based" system unless people making decisions have access to better information. This is a significant problem in Alberta's health system.
- We need more investment in information technology and better information about outcomes in health. If we want a system where the best available information and evidence guides decisions, we need to have the right systems in place to collect, analyse and share information.
- While some good work has been done to measure results, there is an overall lack of standards and targets. Furthermore, there are few rewards for achieving positive results and no penalties if results do not meet expected standards.
- Alberta has a solid reputation in health research and an opportunity to be a leading centre in technology assessment.

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Part II

Recommendations for reform

After reviewing a range of issues and options, the Council has come to the conclusion that, while there are many positive features of Alberta's health system, it's not sustainable without fundamental change. Alberta has an opportunity to lead the country in true health reform. We have an opportunity to reform medicare for the 21st century, revitalize the system, and make sure Albertans continue to have access to the best health care services and the latest in effective new treatments and cures.

In looking at the complex question of how to sustain Alberta's health system, we've taken a long-term approach. Frankly, there are no quick fixes. We believe there are efficiencies to be gained in the health system and we should be vigilant to ensure that we extract maximum value for every dollar spent. At the same time, we are convinced by arguments that suggest there is not much room left for substantial cost savings in the health system simply by cutting administration or looking for efficiencies.

Getting maximum value for what we spend on health is essential. But the Council also believes that both demands for health care services and costs will continue to rise in spite of everyone's best efforts to find better ways of delivering health services at a reasonable cost.

Too often, people have taken the view that, in face of rising costs, our options are limited. We can increase taxes and keep paying more. With that approach, we might be able to buy more health services, more new treatments, drugs and technology. But eventually, health care costs will rise beyond the willingness of taxpayers to foot the bill and health care spending will undoubtedly crowd out other essential government services. The other option is to limit how much we spend and ration services to stay within the boundaries of what budgets allow. That approach contains the supply of health services and helps contain spending. But we know from past experience it does not decrease demand for health services; in fact, it creates a pent-up demand. It doesn't control costs. Costs go up but we're just able to buy less. And people are getting increasingly impatient with long waiting lists or being told new and better treatments and tests are available but they're too expensive so no one can have them.

As a Council, we reject both of those approaches.

Instead, we need to look at better ways of staying healthy, providing more choice and more competition, freeing up the system to introduce new approaches, getting rid of barriers that stand in the way of getting the health services we want, and diversifying the revenue stream so we're not solely dependent on the tax base or government budgets to support health care. We're talking about creating more opportunities, not shutting them off. Giving health providers more opportunities to deliver services to Albertans. Giving regional health authorities more authority to make decisions and more options for delivering the health services their community members want and need. Setting rigorous targets and standards and holding people accountable for the results they achieve. Putting the focus on patients first and giving them more responsibility and more ability to influence how their health care dollars are spent.

Are there some downsides to this approach? Yes. It means not every health care service and treatment will necessarily be covered through public insurance. It means people who can afford it may need to pay more, but they will have more control over what they spend and more choices about how they pay for the health care services they receive. It means we need to abandon some of our old ideas about how health systems work and be willing to say, "Let's give this a try."

In that context, the Premier's Advisory Council recommends that the following ideas and options for consideration.

1. The first reform is to stay healthy.

Too much of the focus in our health system is on treating people when they're sick. The best way of sustaining Alberta's health system in the longer term is to make sure fewer people get ill, suffer from chronic illnesses that can be prevented, get injured in motor vehicle collisions, or compromise their health and the health of others by smoking. It's that simple and that important.

The health of all Albertans should be promoted and improved by taking a global view of all of the factors that determine and affect people's health. This includes basic public health measures, economic well-being, early childhood development, education, housing, nutrition, employment status, quality of the environment, lifestyle choices and healthy behaviours. Actions should be taken at both the population level and by individuals in order to improve overall health. Additional ideas and initiatives already underway are noted earlier in this report.

Consistent with this approach, Council recommends that:

✓ **Because of the profound influence of education on health, government should commit to ensuring that all children have the fullest opportunity to complete high school and a post-secondary education or training program.**

Every child should arrive at kindergarten ready to learn.

Every child should have the opportunity to succeed at school, complete high school and move on to some form of post-secondary education.

Resources should be available to ensure that children have access to early childhood education and pre-kindergarten programs and to make sure all children at risk are identified and their needs are met. With these resources in place, all children should be able to achieve their full potential in school.

✓ **Ensure that appropriate financial assistance is available to support children living in poverty and low income homes.**

Children should have the opportunity to live healthy lives with adequate food, a safe environment, and minimal risks to their own health. Government should ensure that adequate support is available to families who need it.

✓ **Establish a set of clear health objectives and targets for the next ten years, then measure and track progress in meeting those objectives.**

Council suggests that provincial objectives and targets be set in at least the following areas:

- physical activity
- overweight and obesity
- tobacco use
- substance abuse
- injury and violence
- mental health
- environmental quality
- immunization
- access to health care.

✓ **Provide Albertans with better access to evidence-based, reliable information on how to stay healthy and well.**

Alberta Health and Wellness should take on a permanent information role, providing Albertans with up-to-date, evidence-based information about healthy choices and factors that affect health. That role would involve reviewing research and studies of lifestyle and health, analyzing reports, synthesizing information, and providing consistent and reliable information to Albertans and all providers involved in health promotion activities. This would help overcome the current overload of unreliable information from numerous sources and ensure that people have the best information about diet, exercise, smoking cessation, alcohol and drug use, stress and personal control, and defensive behaviours to prevent infection, unintended injury and suicide. It also would improve early detection of disease.

The information assessments and reviews should also be given to all types of health care providers to ensure they have the best and most effective knowledge to provide to their clients.

✓ **Take the lead in updating and introducing a new food guide.**

Canada's food guide is badly out of date and should be updated to reflect the latest evidence and understanding of healthy nutrition. Alberta could take the lead in working with other provinces and the federal government to update the food guide. Food industry partners could be involved in developing and supporting a new food guide and promoting its use as part of their regular marketing efforts.

✓ **Strengthen, update and revise health education in kindergarten to grade 12.**

Current health education programs in schools should be revised to include up-to-date studies and information on staying healthy. Information should be provided by Alberta Health and Wellness as part of its information role.

Students should have the opportunity for regular exercise time as part of every school day. Activities should be tailored to the interests and capabilities of students.

✓ **Provide better incentives for people to stay healthy.**

Too often, people know what they need to do to stay healthy but for whatever reason, they don't make the right choices. The right incentives can make a difference. Ideas such as medical savings accounts would not only give people more responsibility for how they use the health care system, but also could allow them to use their "savings" on a broader range of health promotion and wellness activities and programs. Ideas such as variable premium rates (described later in this report) could also provide an incentive for people to say healthy. Other approaches such as tax credits, tax reductions or credits against health premiums, or partial refunds of health premiums towards the cost of approved personal health promotion programs could also be considered.

✓ **Strengthen support for current initiatives and plans to reduce or eliminate tobacco use.**

A number of initiatives have been planned or are underway but require more concerted effort and financial support to produce better results. That includes:

- Education on the effects of tobacco use as part of a mandatory health theme in schools
- Media-based activities including maintaining an intensive media campaign against smoking (especially initiation of smoking), reviewing media campaigns used internationally and selecting parts or all of those campaigns for use in Alberta
- Pharmacological treatment of and counselling for nicotine addiction, including programs to reimburse people for the costs of approved smoking cessation programs and associated drug costs. Physicians should be encouraged to use the existing counselling fee to cover the costs of providing smoking cessation counselling to their patients.
- Regulation of tobacco advertising and promotion, especially programs targeted at youth
- Clean air regulations, especially bylaws preventing smoking in public establishments
- Restrictions on smoking sales to minors
- Taxation of tobacco products and use of the revenues to pay the costs of programs to provide education, media awareness, and reimbursement for smoking cessation.
- Use of increases in tobacco taxes to support a range of other wellness initiatives.
- Community-based activities, including community efforts to limit smoking especially by youth, and to restrict smoking in public places.

2. It's time to put "customers" first.

Alberta's health system, like every other health system across the country, is focused primarily on hospitals and health care providers. People who use the health system - let's call them "customers" - have little choice in where or how they receive health care services. We're expected to "fit in" with the way services are organized and delivered. Waiting lists cause considerable worry for individuals but most are powerless to do anything about it. As a result, people lose confidence that the health system will be there when they need it or that providers in the system are working together to address their health needs.

Along with the idea that customers should come first, individual Albertans should be expected to take more responsibility for decisions they make about lifestyle choices and how they use the health care system.

Specific recommendations include the following:

✓ **Ensure that all Albertans have guaranteed access to selected health services within 90 days of a diagnosis and recommendation by their physician.**

Albertans should be able to expect reasonable access to necessary medical services. Long waiting times cause worry for patients and may actually add costs to the health system. A 90 day care guarantee for selected services provides an incentive for health authorities and physicians to take appropriate action to manage and shorten waiting lists. Emergency and urgent cases would be dealt with immediately or within a very short period of time.

Patients may need to give up their preference for a specific physician or hospital if they want to be treated within the 90 day period. If regional health authorities are unable to provide service within 90 days, they would have to consider other options for getting the service from another region or within a reasonable distance. Services could be arranged from either a public or private sector provider. If they are unable to arrange services within 90 days, government would arrange for the services in another jurisdiction and the costs would be charged to the region where the patient lives.

✓ **Implement effective ways of reducing waiting lists including centralized booking and posting waiting times for selected procedures on a website.**

Groups of health providers in a region should be encouraged or supported to develop "centralized booking services" to manage waiting lists and arrange for services from the next available specialist. Under this approach, patients would get speedier access to specialist services. They would continue to be able to choose a specific specialist but they may need to wait longer depending on the specialists' availability. Posting waiting times on a website is another practical solution. Instead of waiting on an "unknown" list, patients would have access to waiting times for selected procedures for each hospital and each physician in the province. People could check the website then could consult with their family doctor about getting referred to another physician or facility in their region or in another region with shorter waiting times. If they insist on a particular physician or hospital, they may need to wait longer. Funding for the procedure would follow the patient.

✓ **Give Albertans more choice in the health care services they receive and where they receive them.**

Subsequent recommendations talk about unbundling the health care system, providing more opportunities and more choices. If options like medical savings accounts or other approaches to give individuals more control over how they spend their health care dollars are implemented, individuals would be able to take more control over the kinds of health care services they receive.

✓ **Make new models of care including comprehensive primary health care, disease management or other comprehensive care approaches the norm not the exception.**

We know there are better models of care than expecting individuals to go from one health care provider to another. We can make better use of the full range of health providers and do a better job of keeping people healthy or treating chronic illnesses. Barriers to implementing these kinds of approaches should be identified and removed.

3. Redefine what we mean by "comprehensive."

Medicare, as we know it, was never designed to cover the full range of health services, treatments, drugs and technologies available today or envisioned for the future. Unfortunately, when people talk about "comprehensiveness" - one of the five principles of the Canada Health Act - they believe that every health service and treatment should be publicly insured and provided at no cost to individuals.

It's time to reconsider that assumption and set some boundaries on what will be publicly insured and covered under medicare. If we want to ensure that public coverage is available to treat the most serious illnesses and injuries, or to provide effective treatments to cure people or help them manage their illness, we need to seriously think about re-balancing what gets insured and what doesn't and deciding what services could be funded in other ways.

These are not easy choices. Places like Oregon have gone through detailed reviews of each and every treatment and service to decide if it would be publicly covered or not. The Council does not recommend this kind of detailed treatment by treatment review. However, we do strongly recommend that mechanisms should be in place for reviewing new treatments and technologies and making decisions about what should and should not be publicly funded. We acknowledge how difficult these decisions are and therefore we are recommending that clear processes be put in place without delay. If some services or treatments are taken off the list or decisions are made that new treatments will not be added, those services could still be available in the health system but would be paid for through supplementary insurance, individual payments, or other approaches such as medical savings accounts.

✓ **Establish a permanent expert panel to review and make decisions on which health services and treatments are publicly funded.**

On an initial basis, the expert panel should review the broad categories of services currently provided and decide whether all existing services should be "grandfathered" for continued public funding. Services that are not publicly insured could be provided by the public or private health provider but would not be paid for by public health care funds. The purpose of the review isn't to save money in the short term but to ensure future sustainability by examining the scope of what can and should be publicly funded, now and in the future.

✓ **Require the expert panel to establish criteria for determining whether each new diagnostic treatment, service, or drug should be covered.**

The "rules" for adding new services should be clear to everyone. The process could involve several steps including:

- An evidence-based review to determine whether there are significant and measurable health benefits to Albertans from having access to the new treatment or service and an assessment of whether the proposed new treatment or service is cost effective. A new procedure or treatment might be considered effective if it:
  - △ produces the same result as a conventional procedure but at less cost
  - △ produces a result that is almost as good as the conventional procedure but at dramatically less cost
  - △ produces better results at the same or lesser cost than the conventional procedure
  - △ produces dramatically better results even though the costs are significantly higher, but the increased costs are justified because of significantly improved health outcomes
  - △ provides the most timely and cost-effective way of delivering the procedure or treatment

- If a decision is made that a treatment should be publicly insured, it would be added to the list only if there are sufficient revenues from the province to cover the costs or if other, less useful or less effective services are removed from the list to free up the necessary resources. At the same time, the availability of resources has to be balanced against the need for Albertans to have timely access to new technology, treatments and tests.

4. Invest in technology and establish an electronic health record.

The lack of good information is a serious impediment in Alberta's health system. It means we can't effectively track results, answer basic questions about what is happening in the health system, calculate the cost and benefits of health services, or gather evidence about whether new approaches are effective or not. If the goal is integrated health services, it is essential to have integrated health information and information systems.

✓ **Develop and implement an electronic health record for Albertans, starting with an electronic health care card.**

An integrated electronic health record that tracks individuals' health along with various treatments, medications, and tests would be an invaluable tool for all aspects of the health system. While we recognize that an electronic health record must ensure that privacy and confidentiality are protected, it would provide access to essential information about a person's health, help ensure people get timely and accurate diagnosis and treatment, help track overall use of the health system, and allow better assessment of the outcomes of various health services. The most important benefit is the opportunity to use this information to improve both the health of individuals and the quality of our health care system.

As a starting point, an electronic health care card should be developed. It would act as a kind of debit card for each individual Albertan. It would allow them to see the cost of health services they use and take more responsibility for their own use of the health care system. Regular reports could be provided to Albertans on the cost of the health care services they consume.

In future, if ideas like medical savings accounts or variable premiums are implemented, an electronic health care card would be an essential and practical tool. It also would be a vital component of new models of care like comprehensive primary health care or other disease management models. And it would provide essential information to measure outcomes and help improve the overall health of Albertans.

✓ **Provide long-term provincial funding to support development and implementation of information technology and information technology systems.**

Health systems in Canada, including ours, suffer from a serious under-investment in information technology. This is a major stumbling block in accessing, assessing, and analyzing information about health outcomes and in using information to guide decisions. Information systems should be considered essential costs just as they are in most private sector businesses and should be given higher priority.

Initiatives underway or planned through *alberta wellnet* have the potential to provide improved access to better information in health. Considerable work has been done in developing a pharmacy information network and laying the groundwork for an electronic health record. In spite of frustrations about the lack of deliverables to date, there is a growing sense of urgency that these initiatives must move ahead and move more quickly than in the past. A long-term funding commitment is required along with clear direction and monitoring of results. Government and health authorities should also consider options other than purchasing information technology including contracts, leases, and public/private partnerships.

✓ **Set province-wide standards for information technology.**

Because of the importance of tracking and sharing essential health information, and because of the substantial costs involved in developing and/or purchasing information technology, regional health authorities should not have the option of "going their own way." Council heard examples of health authorities purchasing their own technology and systems which then are incompatible with systems in other regions. Funding for information technology should be tied to complying with the overall direction and standards set by the province. To the extent possible, standards should be compatible with other provinces to ensure that information can be compared on a national basis.

The emphasis should be on developing and/or purchasing the best software and databases that support the development of outcome information. Consideration should be given to purchasing systems that may have already been developed by private sector companies and could be adapted for use in the health system.

✓ **Continue to support the work of the Alberta Heritage Foundation for Medical Research in technology assessment.**

New technologies are being developed on a continuing basis and many of these technologies have a tremendous potential for improving treatment of illnesses and quality of life. At the same time, the costs are high and in some cases, the cost effectiveness of new technologies is not known. Assessing the cost effectiveness of new technologies before they are implemented on a broad scale is an issue that is faced not only in Alberta but across Canada and around the world. The AHFMR has developed considerable expertise in this area. Discussions should also be held with other western provinces with a view to using the capabilities of AHFMR to establish a centre of expertise in technology assessment for the prairie provinces and to share expertise with other provinces and leading centres around the world.

5. Re-configure the health system and encourage more choice, more competition, and more accountability.

As noted earlier in this report, Alberta's health system, like every other health system across Canada, operates as a monopoly. There's little choice or competition. Health services are primarily available only through the public system. Because there is a single provider of health services, there are few incentives to specialize in certain areas, introduce competition, or encourage innovation.

By "unbundling" the system and devolving more responsibility to regional health authorities, it's possible to open things up, expand the range and number of suppliers delivering health care services, and give individuals more choice in the health services they receive.

Council members feel strongly that a "top down" approach to managing and governing Alberta's health system is not effective and does not provide the best incentives for innovation and exploring new options. There is no reason why each health authority in the province needs to operate in the same way with the same ways of delivering services. At the same time, this will present a clear challenge to health authorities. Undoubtedly, some will thrive under a more open and competitive system, while others may find it difficult to operate. The result could be that some regions find it easier to combine their efforts with other regions in order to meet the expectations of their community members.

✓ **Set clear and distinct responsibilities for government and health authorities.**

Under a new approach, government would be responsible for:

- setting overall vision, goals and objectives for the health system including acute care, prevention and promotion, public health, long term care and home care
- preparing annual budgets for health services in the province
- allocating funding to health authorities and other core functions
- investing in health research and sharing information about outcomes
- providing up-to-date and reliable information to Albertans on how to stay healthy
- setting targets and standards
- investing in technology, setting information technology standards, ensuring technology assessment through the Alberta Heritage Foundation for Medical Research
- coordinating health workforce planning and working with professional organizations to coordinate scopes of practice
- paying for certain health services

Regional health authorities would be given responsibility and authority for:

- negotiating overall contracts with the province
- delivering and/or contracting for the delivery of a full range of insured health care services
- establishing service agreements with physicians, labs, private surgical facilities, clinics, groups of health care providers, and private and not-for-profit organizations and agencies to provide health services, including primary health care
- assessing the needs of people in their region, setting priorities and making decisions about programs and services to be provided
- integrating health services across the region
- setting budgets and plans and reporting results to both their community members and the provincial government.

In addition to these responsibilities, Council also understands that a review of ambulance services is underway. While we are not in a position to make any specific recommendations, Council believes that there should be a review of the relationship between emergency services and regional health authorities to assess how emergency services fit with overall health care services.

✓ **Establish multi-year contracts between the province and regional health authorities setting out performance targets to be achieved and budgets to be provided.**

Health authorities are required to provide business and budget plans to the province. But in many cases, they involve only general plans. Specific targets are not set and agreed to by both parties, and budgets are considered "guidelines" rather than limits on what can be spent. By putting contracts in place, the expectations, performance and budget targets for health authorities can be set in clear and open terms. Contracts should clearly spell out what happens if regional health authorities do not manage within their budget targets or do not achieve their performance targets. With contracts in place, regional health authorities should be given the freedom and responsibility for achieving targets and performance standards. Political interference would be minimized. At the same time, as noted by the Auditor General, some regional health authorities may need assistance in developing sound governance and management practices to ensure that they are well managed and meet the objectives of their contract with the province.

✓ **Facilitate cooperation among regional health authorities and use evidence from performance contracts to assess the effectiveness and viability of regions on an ongoing basis.**

Council members had considerable debate about the number of health regions in the province. Many people suggest that Alberta has too many regions for the size of its population. On the one hand, reducing the number of regions might result in better integration and streamlining of services. On the other hand, there is little evidence to suggest that fewer regions would result in better health outcomes or significant savings. Council believes that it makes good sense for regions to work together in areas where they can achieve efficiencies and deliver better services, especially in the areas of administration, technology, and procurement. Evidence from contracts between regions and the government should be used to assess regions' performance on an ongoing basis. If regions choose to duplicate efforts when cooperative approaches would have worked better and saved money or where outcomes or management are not up to standard, government should consider blending entire regions or parts of regions.

✓ **Encourage health authorities to contract with a wide variety of providers including other regions, clinics, private and not-for-profit providers, and groups of health providers.**

Currently, the majority of health services are provided directly by health authorities. Lab services, long term care, and home care are examples where services are frequently provided through contracts with private and not-for-profit organizations.

The Council feels it is important to open up opportunities and encourage more options in the health system.

Health authorities should have the option of contracting with other health regions for certain health services. For example, based on past trends, a region may anticipate it will need 50 hip replacements in a year. It could seek competitive bids from other regions able to provide the service. Contracts could be awarded based on a number of factors including price, waiting times, transportation arrangements, and follow-up care.

Similarly, regions should be able to enter into contractual arrangements to offer joint services to people in adjoining regions, jointly hire physicians to provide specialized services, do joint procurement and purchasing to capitalize on their combined purchasing power, jointly purchase and support information technology services, or provide joint administration. Currently, there are few incentives in place for regions to enter into these kinds of agreements.

In the longer term, regional health authorities could consider establishing contracts with hospitals in their region as well as alternative ownership arrangements and payment mechanisms.

✓ **Encourage health authorities to develop centres of specialization.**

Several regions have developed effective programs for treating people with Alzheimer's disease, providing certain surgeries or treating certain conditions. More specialization and development of centres of specialization should be encouraged. The Council believes that this is an important way of improving the quality of services. Regions with special expertise should be able to "market" those services to other regions and enter into contracts with other regions to deliver services. In this way, regions would generate a sufficient volume of services to allow them to achieve better outcomes.

✓ **Implement new models of care including comprehensive primary health care, disease management and other comprehensive care approaches.**

These approaches provide the kind of care many people want. Various studies and evaluations suggest that primary health care is effective in coordinating a wide range of health and related services and improving health. Disease management approaches can help people manage chronic health conditions and avoid more expensive and serious treatments. They also have a tremendous potential to improve outcomes. More providers should be encouraged and supported to implement these approaches. Albertans should be informed of the

benefits of these kinds of comprehensive approaches and whether or not they are available in their communities. If new funding approaches were implemented to give people more control over where they choose to access health services, people who prefer a more comprehensive approach would be able to choose clinics or providers who opt for this approach rather than being referred from one service to the next.

One of the concerns in the health system is that the full potential for drugs to improve health and reduce costs in other aspects of the health system is often not reached because there aren't effective programs in place to manage patient drug use. There is an opportunity for Alberta to take a leadership role in introducing new disease management partnerships to address this issue. Council recommends that government should work with the pharmaceutical industry, health authorities and health providers to develop multi-stakeholder disease management and educational programs.

Perhaps the most critical issue in implementing new models of care is to expand alternative ways of paying physicians. Council's recommendations on alternative payment approaches for physicians are outlined later in this report.

✓ **Encourage an innovative blend of public, private and not-for-profit organizations and facilities to deliver health care services.**

Instead of saying all insured services must be provided only in the public system, it's time we looked at an innovative blend of private and public health care services and facilities. As long as insured health care services are publicly funded and standards are in place, it should make no difference if services are delivered in public, private, or not-for-profit facilities. Regional health authorities should be in a neutral position and be able to purchase services from either the public or private sector depending on where there is capacity and whether they can get services at a reasonable price.

Physicians should be able to work in public, private or not-for-profit systems and retain their privileges at public hospitals. In fact, physicians should be required to work a percentage of their time in the public system to ensure that the best talent is available to both the public system and private health care facilities. This approach is supported by physicians who currently work in the private sector. They suggest that physicians should be required to work in the public system to keep their skills sharp - the public system provides more variety in cases and allows physicians to treat more complex cases than would be allowed in the private or not-for-profit sector. The percentage of time physicians spend in the public or private sector should be a flexible arrangement depending on the type of care provided and should be determined by regional health authorities and the College of Physicians and Surgeons.

✓ **Encourage groups of health care providers to establish "care groups" and offer a range of services to individuals and health authorities.**

Health care providers should have more opportunities to deliver the kind of health services Albertans want and need. Currently, opportunities are limited by existing ways of delivering services or budget limitations. With new models of care and diversified sources of revenues, groups of health care providers could set up health care organizations on a business model and market their services both to individual Albertans and regional health authorities and provide insured as well as uninsured health services.

✓ **Integrate mental health services with the work of regional health authorities.**

Although the Alberta Mental Health Board has served a useful role in the past, it's critical that mental health services be fully integrated with other health services available in the region. Therefore, the Council recommends that mental health services should be the responsibility of regional health authorities across the province. Clear guidelines should be in place to ensure that mental health services receive a high priority in the regions and that spending on mental health services is maintained and enhanced. The government should set province-wide standards and those standards, performance measures and targets should be reflected in contracts with regional health authorities. Health authorities should be accountable for meeting the mental health needs of people in their region and the targets set in their contracts.

Provincial leadership is required to anticipate growing needs for mental health services for specific groups including seniors, children and adolescents. Appropriate resources should be available to meet these growing needs and ensure that adequate programs and services are available.

6. Diversify the revenue stream. Instead of rationing health services, we need to find better ways of paying for the health services Albertans want and need.

We need to begin by extracting maximum value for every dollar spent on health care in the province. But containing costs, seeking efficiencies, and streamlining delivery of health care services may not produce enough savings to sustain the health system over time - especially in the face of growing demands and rising costs.

If we continue to depend only on provincial and federal revenues to support health care services, we have few options other than rationing health care services. On the other hand, if we are able to diversify the revenue sources used to support health care, we have the opportunity of improving access, expanding health care services, and realizing the potential of new techniques and treatments to improve health.

Council recommends the following ideas for consideration.

✓ **Ensure that government continues to fund the majority of health care costs, but that increases are affordable.**

Diversifying the revenue stream does not mean government can duck its responsibility for continuing to provide substantial support for Alberta's health system. Whatever changes are introduced to reform and change the health system, it is likely that health care will continue to be the number one priority for government spending.

The challenge is to find effective ways of moderating annual increases in spending so they are affordable, match growth in the province's economy and do not compromise the province's ability to deliver other essential services like education, infrastructure or security.

Several options could be considered.

- A ceiling could be set so that health care funding does not take up more than a fixed percentage of government spending in a year.
- Targets could be set for annual spending increases based on a number of factors including population growth, aging, inflation, and growth in the province's economy.
- Health authorities could be given fixed, multi-year budgets and contracts with no adjustments during the course of the approved budget except under extenuating circumstances.
- Decisions could continue to be made on an annual or multi-year basis taking into account changes in the province's fiscal situation and needs identified by health authorities.

While Council is not in a position to recommend one approach over another, we recognize the continuing tension between:

- the need for government to curb the trend for annual increases beyond what is affordable
- health authorities' need for adequate funding to meet increasing costs and demands and the need for more stability in funding over time.

In the longer term, many of the Council's recommendations for re-configuring the system should help moderate increasing costs, but in the short term, these ideas will not relieve pressure on provincial budgets.

✓ **Set clear principles to guide decisions on new sources of revenue to support Alberta's health care system.**

Council members have come to the conclusion that the current health care system is not sustainable if it is solely funded from provincial and federal government budgets. Our recommendations to diversify the revenue streams are based on a fundamental view that all Albertans deserve fair and equitable access to health services. Rather than rationing health services, we need to look at a variety of options for generating additional revenue and using that revenue to expand opportunities for Albertans to access the health services they want and need on a timely basis.

The following are the essential principles that should guide decisions about various options for additional sources of revenue:

- No Albertans should be denied access to health services because they are unable to pay and no Albertans should get better or quicker access to essential health services because they are able or willing to pay for it.
- All Albertans should be fully covered for catastrophic illnesses and injuries.
- People with low or no income, including seniors, must be protected.
- There should be incentives for people to stay healthy and improve their own health.
- Customers should come first. Any new revenue approaches should give individuals more choices, a greater ability to make decisions about their own health, and should encourage them to make the best use of the health system. Along with this comes a recognition that Albertans must take more responsibility for their own health and the decisions they make.
- Innovation should be encouraged and supported.

- New sources of revenue should be used to enhance flexibility, encourage more options and choices in the system, and improve access to health services.
- New sources of revenue should support stability and encourage savings by individuals against future costs of health care services.
- New approaches to funding health services should be assessed based on simplicity, administrative feasibility and costs of implementation.

✓ **Explore and implement a "made in Alberta" approach to funding health care services in the province.**

Council believes that a "made in Alberta" approach to funding health care services can and should be developed. A number of ideas and options have been considered but the Council has not had time to do detailed feasibility studies on the potential impact of various options.

The various options should be assessed based on the above-noted principles and the extent to which they meet a number of different objectives for the health system.

The range of possible options for raising additional revenue includes:

- increasing health care premiums
- introducing user fees
- using the income tax system to "tax" people for the health care services they use
- establishing a special health care tax
- allowing privately funded and privately delivered health services
- expanding supplementary or private insurance
- implementing a form of medical savings accounts
- introducing variable premiums, deductibles or other forms of co-payments
- some combination of the above options.

On an initial basis, the following are some of the advantages, disadvantages and views of the Council on each of these options.

- **Increasing health care premiums**

Alberta is one of two provinces that charges health care premiums as part of a health care insurance plan. In 1969, when premiums were first introduced, they made up about 17% of health services including payments to doctors, hospital and health authority boards, mental health services, drug benefits, ambulances, vaccines, blood services, and so on (but excluding department administration and capital costs). Health care premiums have not kept pace with rising costs or the expanding scope of insured services. The last increase in health care premiums was in 1995-96. At that time, the percentage of the cost of services covered by premiums had fallen below 17%. Premiums currently cover about 11% of health care costs.

The advantage of increasing health care premiums is that it would raise additional revenue to support the health system and it would remind Albertans that the costs of health services are significant. Many would argue that for the cost and value of health care services people receive, paying $34 a month as an individual or $68 a month for families is a pretty good deal, especially when low income people pay low or no health care premiums. Raising premiums is administratively simple. On the other hand, increasing premiums would have no effect on moderating demand for health care services. If decisions are made to increase health care premiums, there should be corresponding benefits to Albertans including more choice, better access, and more control over how they spend their health care investment.

- **User fees**

  Many countries charge user fees for health services including Australia, Germany, the Netherlands, Sweden and the United Kingdom. In those countries, user fees are intended to reduce demand, assuming that if people have to pay a portion of the real costs of a service, they will be more careful in consuming health services. However, user fees charged at the point of service contravene the Canada Health Act. Canada is the only industrialized country that prohibits user charges for publicly funded health services. Evidence also suggests that while user fees may reduce demand, they also are a much greater barrier to care for people with low incomes. For this reason, Council has concerns about establishing user fees paid at the point of service.

- **Making health care services "taxable benefits"**

  Under this approach, records would be kept of the cost of health services consumed by individuals during the year. At the end of the year, people would have to pay a certain amount of tax based on their income and the cost of the services they used up to a maximum level to ensure that, regardless of income, individuals are not bankrupted by catastrophic illness.

  This approach has the benefit of ensuring that those with higher incomes pay more for the health care services they use than people with lower incomes. Knowing that health care services you use will end up costing you at income tax time may also be a way of moderating demand. In effect, making health care services taxable benefits is a form of user fee that is graduated according to people's level of taxable income.

  On the downside, this approach would mean financial hardship to some people. It also adds complexity to the income tax system. It does not have the visibility of other approaches because many people don't realize how much they pay in income tax. And people may see this as a "double payment" since they already pay for health care through provincial and federal income taxes. In general, Council does not support making health care a taxable benefit.

- **Introducing a dedicated health tax**

  Some have suggested a dedicated tax could be introduced to support health care services. The tax could be added to the income tax system or be set up as a consumption tax similar to a sales tax. On the positive side, a dedicated tax would raise additional revenues, would reflect Albertans' commitment to health care, and would help raise awareness of the costs of health care. On the negative side, many Albertans would likely object to increasing taxes and there would be strong objections to any form of a sales tax, even if it was dedicated to health care. For these reasons, Council does not support this option.

- **Supplementary insurance**

  Currently, Albertans can get supplementary insurance to cover services such as drugs, dental services, and ambulance care through Alberta Blue Cross. Many people have supplementary benefit plans through their employers that provide additional coverage for certain health services. In view of increasing demands for health services and an expanding range of health services that may or may not be publicly insured, one option would be to expand the scope of supplementary insurance available to Albertans. Supplementary insurance, provided by either public or private sector organizations, could be used for a range of services including expanded home care and long term care or for providing access to new treatments and diagnostic tests that may not be publicly insured.

The advantage of this approach is that it allows people to invest in additional health care coverage. It expands people's ability to access a broader range of health services than might be available under the publicly funded system. And it allows people to plan ahead for when they may need additional health services. On the other hand, supplementary insurance adds costs to individuals and unless appropriate regulations are in place, people with certain health conditions could be denied access to supplementary insurance plans. Low income people also may not be able to benefit from these plans.

Council believes that there could be an expanding emphasis on supplementary insurance to cover new services that may not be publicly insured or covered such as new diagnostic tests, drugs, alternative or complementary health services, or expanded home care and long term care. While we do not recommend expanding private insurance for publicly funded services, if effective steps are not taken to improve access to these services, an expansion of privately insured and privately delivered services may become necessary.

- **Privately funded and privately delivered health services**

Perhaps the most contentious option involves expanding the range of health services that would be available in a completely private health system. Under the current system, all insured health services are paid for publicly. The services are mostly delivered in public facilities such as hospitals, clinics or health centres, but some can be offered in private facilities provided there is a contract in place with a regional health authority and the services are publicly funded. People are not allowed to pay directly for access to publicly insured services. They can't pay for quicker access in a private facility, although some people can and do go to the United States for treatment at their own expense.

Under this option, a parallel private system would be allowed. People would be able to choose to get both insured and non-insured health services in a private facility. They could pay for these services directly or through some form of private or supplementary insurance. The public system would continue to provide the full range of insured health services.

On the one hand, some people argue that opening up more private options would take pressure off the public system. People who could afford to pay more would be able to use the private system and open up more space for services in the public system. This option would provide the most choice to consumers. And some argue that unless the public system is able to find better ways of meeting increasing demands for new tests and treatments and shortening waiting times, the expansion of privately funded, privately delivered health services may be inevitable.

On the other hand, this approach would clearly contravene the Canada Health Act. People argue that experience with this approach in other countries shows it has a negative impact on the public health system. Many people feel that the best physicians are more likely to work in the private system, simpler procedures would be done in the private system while the most complex and costly ones remain in the public system, and there would be little control over increasing costs. There also is a concern that wealthier people get better access to health care while those with low or no income are disadvantaged.

The arguments for and against private health care are not new and the issue has been the subject of heated debates, especially in Alberta. The Council's view is that, while a privately funded and privately delivered health system may provide the most choice, it certainly is not our preference. We believe there are better solutions for Alberta. As noted earlier in our report, we support an innovative blend of public and privately delivered health services - delivered under contract with regional health authorities and publicly funded.

- **Medical savings accounts**

As a Council, we spent considerable time exploring the idea of medical savings accounts. In basic terms, medical savings accounts could look like this.

Individuals have a set amount allocated to their medical savings account for the year. This could be the equivalent of their health care premium (at whatever level that is set) or it could be a combination of their health care premium and additional funding from the province. The amount each person receives is adjusted for certain factors including sex and age. Government would continue to pay premiums on behalf of low income people and deposit that amount in their medical savings account.

Individuals could use their medical savings account to pay for insured health care services used during the year. On an initial basis, hospital costs would not be included but all other services would. Individuals would have the ability to choose which health services they used during the year, choose who they "purchase" those services from, and where possible and appropriate, shop around to see where they can get the best price.

If individuals use up all the money in their medical savings account during the year, two options are possible. They could be required to pay for additional services up to an annual maximum amount (the so-called "corridor" between medical savings account coverage and the point at which medicare coverage kicks in). Or government would pick up all costs of needed health services just as they do now. In this latter case, there would be no penalty for using up all of the medical savings account. This is a key design feature, and would have to be carefully analyzed to ensure that any medical savings account scheme maximized equity while improving incentives for people to use the health care system prudently.

At the end of the year, if individuals have not used all the money in their medical savings account, they get to keep it. This provides an incentive for people not to spend all of the money in their medical savings account. The remaining amount could be rolled over into a separate savings account. Accumulated savings might be used to purchase a wider array of health services including services to help people stay healthy such as smoking cessation programs, dietary counselling, fitness training, or other services currently not publicly covered. Individuals could choose to save the money to use in the future for home care or long term care. Depending on how the medical savings accounts were designed, people could be required to use all or a portion of their past "savings" to pay for essential health services.

Each year, the annual amount would be replenished by the individual's health care premiums.

There are a number of advantages of this approach.

- It gives individuals more control over how they use the health care system and how much they spend. It also increases awareness of the cost of health care services.
- It encourages health authorities and health providers to be more responsive to the needs of their "customers."
- Depending on how the Medical Savings Accounts are designed, it might allow individuals to access a broader range of health care services than is currently covered under public insurance.
- It could be designed to include a pool of money that individuals could use on a variety of health promotion and wellness initiatives.
- It gives people the opportunity to plan ahead for a time when they may need expanded services for home care and long term care.
- It increases accountability because health care providers would have to calculate the cost of health care services and inform consumers about the costs.

On the other hand, some concerns have been raised.

- It would increase costs to government and may add administration costs.
- If individuals were allowed to use their savings on a broader range of health care services, it might, in effect, expand public coverage for health services we currently do not pay for and costs would increase as a result.
- The reward of accumulating savings may not be sufficient to act as an incentive for people to economize on their use of the health system.
- If there is no "corridor", there is little disincentive to use up all of the annual amount, (e.g. if government automatically provides full coverage when the annual amount is used up). On the other hand, if people are required to pay for some services once their medical savings account is exhausted, this may contravene the Canada Health Act.
- Some suggest that the major benefits of the approach go to people who are young, healthy and have high incomes while the benefits to older people, people with ongoing or chronic health conditions or low incomes are not as great but, again, such outcomes are highly dependent on the way the scheme is designed.

- **Variable premiums and an Alberta health care account**

Another option worth exploring is one where individuals would be expected to use their health care premiums to pay a co-payment for using health care services. This approach is similar to an insurance plan where you pay a deductible based on the services you use.

The basic features of this approach would be as follows:

Each adult would pay health care premiums just as they do now. But under this scheme, children would be exempt. Low income people would be exempt as they are now and health care premiums would continue to be subsidized for low income individuals and seniors.

To ensure future sustainability, health care premiums would be tied to increases in overall spending on health care. If costs of health care increase and if the scope of publicly insured health care services expands, health care premiums would increase at a similar rate.

Individuals' health care premiums would be deposited into a personal Alberta health care account.

All adults would use their health care account to "pay" a co-payment for a fixed portion of the health care services they use. This would include all publicly insured health services. Some services such as highly intensive surgeries, transplants, etc. could be exempt and exemptions could also be included for people who are chronically ill. The co-payment could be set at a fixed percentage of the cost of health services (say 20%). If electronic health care cards were in place, individuals could use this card as a form of debit card to withdraw funds from their health care account each time they use a health service. Quarterly statements would be sent from Alberta Health and Wellness to provide information on the status of each person's health care account.

If individuals do not use up the full amount of their health care account in a given year, they could save that amount against future years when they may require more health services.

If individuals use up the full amount of their health care account, they would be charged a "premium supplement." The maximum amount people would be expected to pay for both their base health care premium and a premium supplement would be set at a fixed percentage (say 3%) of their taxable income. People with low incomes would be exempt. When people receive their quarterly statement from Alberta Health and Wellness, if they have used up the full amount of their health care account, it would show the amount they owe as a premium supplement. No payments would be required from individuals when they actually receive health care services. All additional costs would be borne by government.

On the positive side, this option:

- Provides individuals with more control of their health care spending (they control how their health care premiums are spent) and increases their awareness of the costs of services they use
- Provides an incentive for people to use the health care system appropriately
- Would not increase health care costs to government although there may be added administration costs
- Allows individuals to plan ahead for years when their annual health care spending could be larger than the amount in their health care account
- Increases accountability because health care providers would have to calculate the cost of various health services and inform consumers

On the other hand, this approach:

- Does not allow people to use savings in their health care account for expanded health care services or health promotion and prevention programs
- May not provide as much of an incentive for people to economize on their use of the health care system because their co-payment amounts to only 20% of the cost of services
- May not provide as much of an incentive for health authorities and health care providers to be responsive to the needs of their "customers" when individuals are only paying for 20% of the costs of a service
- May be viewed as onerous for those who pay up to 3% of their taxable income in supplementary health care premiums
- Would involve administrative costs to implement.

A comparison of the various options with a number of important objectives of the health system shows the strengths and weaknesses of each of the options.

Options and objectives

	Increase premiums	User fees	Taxable benefits	Health tax	Private funding/ Delivery	Supple-mentary Insurance	Medical savings	Variable premiums accounts
Raise revenue - unrelated to use	✓			✓				
Moderate use of health services		✓	✓				✓	✓
Increase choice/ Control for consumer		✓	✓		✓	✓	✓	✓
Promote wellness			✓			✓	✓	✓
Address sustain-ability	✓	✓	✓	✓	✓		✓	✓
Improve access*	✓		✓	✓	✓	✓	✓	✓
Increase account-ability		✓	✓				✓	✓

*Assumes additional revenue would be used to improve access. For supplementary insurance, access to uninsured services would be improved; no impact on insured services. User fees are not expected to improve access because amounts of money raised would likely be small. Medical savings accounts and variable premiums could increase access because they provide individuals with the ability to control how their health account is spent and also to save against future costs.

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Increase choice/ Control for consumer		✓	✓		✓	✓	✓	✓
Promote wellness			✓			✓	✓	✓
Address sustain-ability	✓	✓	✓	✓	✓		✓	✓
Improve access*	✓		✓	✓	✓	✓	✓	✓
Increase account-ability		✓	✓				✓	✓

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Based on our assessment of the various options, Council recommends that the following steps should be taken:

- **Health care premiums should be tied to the overall costs of the health system and the scope of insured services.**

  Health care premiums have not increased to keep pace with rising costs or the expanding scope of insured services. As noted earlier, when premiums were first introduced, they made up about 17% of the costs of health services but that percentage has since slipped to about 11%. Increases in health care premiums should be phased in so that premiums make up 20% of the overall costs of insured health services. Health care premiums should also be linked to the scope of insured services paid for and covered. As new treatments, tests, and services are added, the cost of health care premiums should rise at a corresponding rate.

- **A unique Alberta approach should be developed for funding health services.**

  Two options - medical savings accounts and variable premiums in an Alberta health care account - have the most positive features and warrant further study. These approaches have the benefits of providing individuals with more control over their health spending, encouraging best use of health services, allowing people to save against future costs, and improving accountability. More detailed studies should address questions such as:

  - △ whether similar approaches have been implemented in other jurisdictions and what the impact has been
  - △ how medical savings accounts or a variable premium approach would be administered and managed
  - △ how funds would be invested and whether interest would be added
  - △ how funds from medical savings accounts or a variable premium approach would be transferred to regional health authorities and health providers
  - △ how the costs of various health services would be determined
  - △ what kinds of services would be included or excluded
  - △ what the impact would be on people with various incomes
  - △ what the costs or potential savings would be.

  Based on further evaluation, the Council recommends that a new Alberta approach should be designed to meet the principles identified by Council and help ensure a sustainable health system for the future.

✓ **Work with the provinces to put national strategies in place to manage and contain increasing drug costs.**

New drugs and pharmaceuticals have tremendous benefits in terms of improving quality of life, managing illnesses and, in some cases, precluding the need for more extensive surgeries or other treatments. New drugs for treating auto-immune diseases such as arthritis and multiple sclerosis may be costly but they have a very positive impact on the individuals involved and often reduce other costs in hospitals and long term care facilities. While the benefits are substantial, the costs of new drugs are also growing at a dramatic rate. Provincial and territorial Ministers are working together to explore ideas such as joint purchasing of pharmaceuticals or a national formulary. Council does not have specific recommendations to make on this issue but believes that solutions must be found on a national basis not within each province independently.

✓ **Allow regional health authorities to raise additional revenues to pay for services they provide.**

Currently, the majority of regional health authorities' funding comes from the provincial government and they have few sources of additional revenues aside from minor items like parking fees. Many have foundations in place that raise charitable donations to support equipment, capital or specialized programs and services. Concerns have been raised that, in some cases, there need to be better linkages between foundations and the ongoing priorities of regional health authorities.

Regional health authorities currently provide a number of uninsured services at no cost to those who use the service. Examples where they could raise additional funds include:

- charging fees for long-term care that come closer to covering a portion of the actual costs
- implementing co-payments for home care (as recommended in the Task Force report on long-term care)
- removing regulatory barriers so health authorities can support construction of assisted living spaces not just nursing homes
- charging fees for restaurant inspections, environmental assessments, and public education programs.

Regional health authorities should be allowed to increase fees for these services. They also should be encouraged to develop centres of specialization and market their expertise to other regions, other provinces and perhaps even to people in neighbouring states.

7. Put better incentives in place for attracting, retaining and making the best use of health providers.

There are serious problems with all aspects of the health workforce. The current shortages are caused by a number of factors including: reductions to the number of health providers educated at post secondary institutions, low morale, dissatisfaction with the workplace and quality of work-life, frustrations, and better opportunities outside the country.

We also haven't been successful in providing integrated care for patients or in providing the right incentives for health providers to provide integrated care. We need to remove current disincentives to the kind of care people want to see and replace them with better incentives and opportunities for the health workforce.

Instead of looking at short-term, quick-fix solutions, we should be looking at long-term strategies that build a more stable supply of health providers, anticipate changes in what health providers do and how they work together, and create a more positive working environment. This should be a recurring theme in the health system rather than a periodic attack on doctors, nurses and regional health authorities.

The following actions should be taken to address these concerns.

✓ **Work with regions, professions/providers and post-secondary institutions to develop a comprehensive workforce plan that includes all aspects of the health care system including acute care institutions, community health, long term care and home care.**

We're not suggesting a central planning approach where specific numbers are forecast for each profession and translated into enrolments at post-secondary institutions. These approaches have not been successful in the past. But we should be able to do a better job of anticipating changes in the roles of various health providers, looking at changing health needs in the population, and anticipating trends in the workforce.

A comprehensive workforce plan should be built on an appropriate assignment of work in relation to the qualifications, skills and training of various health providers.

- This component of the plan should address questions such as: What is the most effective mix of health providers? What role should licensed practical nurses play in relation to registered nurses? What is the role of nurse practitioners in relation to services currently provided by physicians? Can pharmacists play an expanded role in prescribing medications under certain conditions? How can we best respond to the growing need for mental health practitioners?

- The objective is not to be prescriptive but to identify the scope of practice for the various health providers and to identify how they can provide more integrated care for patients.

Professional colleges and unions should be challenged to review the respective roles of their members and take a more proactive approach to build better working relationships with other health professions rather than simply "protecting turf."

The workforce plan should guide decisions by government, medical and nursing faculties, and other university programs, colleges and technical institutes, on the anticipated numbers of health care providers, and the level of funding required to meet future demands.

On a more immediate basis, the role of nurse practitioners should be expanded, current restrictions limiting the use of nurse practitioners should be removed, and education programs for clinical nurse specialists should be expanded. Use of licensed practical nurses should also be expanded.

✓ **Encourage regional health authorities to develop and implement strategic initiatives to improve workforce morale for all health providers with the long term goal of increasing work satisfaction and improving retention of the workforce.**

Specific initiatives would vary among regions but should include strategies to:

- Address staffing issues - such as workload, scheduling and use of support staff
- Reward effort and achievement - such as recognizing people who act as mentors for other providers and addressing quality of life issues
- Strengthen organizational structures - such as addressing the impact of policies on staff, contractors, independent professionals and patients, clarifying roles of various providers, encouraging teams, involving people in decision making, and ensuring good communication
- Support leadership and professional development - such as involving nurses in management positions, promoting more meaningful involvement in governance and decision making
- Promote workplace health and safety - such as monitoring health and safety of employees and providing a safe environment
- Provide learning opportunities - such as expanding opportunities for continuing education and providing flexibility for employees to participate
- Promote recruitment and retention - such as creative job design, flexible hours, or involving employees and educators in recruitment.

✓ **Implement alternative approaches for paying physicians for their services and providing better alignment between physicians, regional health authorities and the goals of the health system.**

Council consistently heard that the way in which physicians are paid is an almost insurmountable barrier to change. We strongly believe that new models of comprehensive primary care and other models of disease management are critical to improving health and health outcomes. But the current method of paying physicians on a fee for service basis is a major barrier to implementing these new models of care.

Physicians who would like to opt for a different payment approach do not have the flexibility they need to provide their patients with more comprehensive care. Past experience with alternative payment plans in Alberta has been difficult and frustrating to those involved and has met with only limited success. The administrative burden has been high, months of work goes into getting each new arrangement off the ground, and although patients are very supportive of the care they get, physicians are frustrated with the burden it places on them without corresponding compensation.

Some physicians are concerned that the current fee for service approach puts added stress on physicians and requires them to see increasing numbers of patients in order to generate a reasonable income. They compare this approach to a "treadmill" where they're working harder and faster but not moving ahead. On the other hand, other physicians feel strongly that fee for service is the best approach and no fundamental changes are needed.

The other pressing issue is the relationship between physicians and regional health authorities. Under the current system, the vast majority of physicians have no direct relationship with regional health authorities. And yet their decisions on surgeries, diagnostic and lab tests, and treatments drive many of the costs for regional health authorities. Physicians negotiate with the provincial government to determine their payment schedule and the overall amount to be paid to physicians each year. Regional health authorities have no role in these negotiations.

Some have suggested that the budget for physician services should be allocated to regional health authorities and they should be able to contract with physicians for their services. This would allow them to develop a more direct relationship with physicians, encourage more flexible options, and anticipate and manage costs. On the other hand, others suggest that most physicians would object strongly to this arrangement and prefer to continue the current arrangement where the province is responsible for all physician payments.

A number of alternative ways of addressing these issues and paying physicians in a different way have been tried both here in Alberta and elsewhere. The options generally include:

- **Capitation or rostering approaches,** where physicians are paid for providing a set range of health services to a set number of patients. The advantages of this approach are that physicians are able to provide a range of health services to their patients including services from a team of other providers. They can help their patients stay healthy, not just treat them when they are ill. There are better incentives for providing comprehensive care to patients and less incentive to provide more treatments to more patients. On the other hand, experience with these models shows high administrative costs in tracking patients and their use of the health system.

- **Alternative funding or payment plans,** where groups of physicians are paid a negotiated amount for providing an agreed upon range of services to a population of patients (e.g. patients with a disease of a particular organ system). This model has worked particularly well for certain specialty groups in other jurisdictions.

- **Salaries,** where physicians are paid a specified annual amount based on the type of work they do rather than the volume of services they provide or patients they service. The advantage of this approach is that physicians have a set salary and they know how much they will be paid in a year, regardless of the volume of patients or services they provide. However, depending on how high the salary is, it may be a financial disadvantage to physicians. It also may not provide an incentive to serve more patients at a time when Alberta is facing a shortage of physicians.

- **Fee for service approaches,** where physicians are paid a fee for each service they provide. The advantage is that physicians are paid for what they do; there is a direct relationship between the services they provide and how much they are paid. The disadvantage is that this system provides a natural incentive to see more patients more often and provide more health services. Fee for service acts as a disincentive for time consuming visits that are often more effective in promoting their patients' health and for counselling. Unless the fee for service approach builds in payments for counselling or comprehensive care, physicians are not paid for taking steps to keep their patients healthy.

- **Combination of fee for service and a "grant" for comprehensive care.** Under this approach, physicians would be paid a fee for certain services and a "flat fee" or grant for more comprehensive services designed to monitor patients' health and help keep them healthy. The advantage is that it blends the best features of fee for service and rostering approaches. On the other hand, it may add costs to the budget for physician services.

- **Contracts between regional health authorities and physicians,** where a budget would be allocated to regional health authorities and they would use that budget to contract for certain services with physicians in their region. Under this approach, a portion of the budget for physician services could be allocated to regional health authorities as a pool of money for contracting services with physicians. Groups of physicians would have the choice of contracting with regional health authorities or remaining under the existing fee for service or other approaches.

Experience with these various approaches shows that no one model is best for all physicians in all circumstances. A blended approach, combining the best features of a variety of approaches, is likely best. Physicians also should have more flexibility in choosing the option that works best for them, their patients, and their community.

An excellent example of new, blended approaches is the recently announced agreement between the Ontario Medical Association and the Government of Ontario. Under this arrangement, people who sign up with a doctor in one of the family health networks will get access to physician services 24 hours a day, seven days a week through a combination of extended office hours, telephone "triage" and consultation with a physician who is on call. Physicians who are part of family health networks are expected to provide a full range of primary health care services, diagnostic tests and treatments, mental health care, patient education and preventive care, support for hospital, home and long-term care, and coordination of services and referral. They are paid on the basis of a combination of factors including the number of patients served, their age

and sex, the fee codes for the various core services provided, as well as special incentives for preventive care management including pap smears, mammography, flu vaccinations, and immunizations for children. The arrangement also includes a number of other special payments. To assist in implementing the new arrangements, the government will provide support for management and leadership, implementing telephone health advice services, and implementation of primary care information technology. Examples like the Ontario approach certainly deserve further study in Alberta.

Council acknowledges that raising the issue of how physicians are paid is sensitive and yet the issue needs to be addressed and resolved. A single solution, mandated by "command" would not be accepted by physicians. At the same time, progress has been slow, the number of alternative approaches in place is small, and something has to be done to break the logjam. The issue is fundamentally about improving quality of care. Council believes that physicians, government and regional health authorities should actively and vigorously seek alternative funding arrangements in order to improve the quality of care and move ahead with comprehensive primary health care and disease management approaches.

New approaches to paying physicians should meet a number of important objectives including:

- Providing quality care, better outcomes and better care for patients
- Facilitating comprehensive primary care (including health promotion) and disease management approaches
- Providing flexibility for physicians
- Reflecting evidence and experience about which approaches work best to achieve better outcomes for patients and physicians.

With those objectives in mind, Council recommends that:

- **Government should take the lead in negotiating new payment arrangements for physicians.**

  Contract negotiations between government and the Alberta Medical Association are set to begin again in the new year (2002). Government should send a strong signal that alternative ways of paying physicians will be implemented as part of a new agreement. The approach should go beyond the current pilot projects, simplify administration, and expand the range of options available to physicians. The Alberta Medical Association should encourage more flexibility and support more choices for physicians who prefer different ways of practicing and being paid.

- **Blended approaches to paying primary care physicians should be developed and implemented, including options providing a combination of fee for service and a grant for comprehensive care.**

  Council believes a "one size fits all" approach is not advisable. A blended approach allows physicians to be paid on a fee for service basis for specific treatments but also combines the features of a rostering approach where physicians are paid a flat amount for providing comprehensive services. This "grant" or flat rate could be used to expand the use of multi-disciplinary teams, provide services designed to help patients stay healthy or treat specific illnesses. The "grant" could also be established as a fee for comprehensive care. This approach and models similar to the Ontario example should be studied further with a view to early implementation in Alberta.

- **A portion of the budget for physicians' services should be allocated to regional health authorities for contracting with physicians in their region.**

  Physicians should be able to choose the option of entering into contracts with regional health authorities. While a wholesale change to contracting with regional health authorities is not likely, it may be possible to allocate a portion of the budget for physician services (say 25%) to regional health authorities as a pool of money for contracting services with physicians. Groups of physicians who want to opt for an alternative approach or want to provide comprehensive care could choose to contract with regional health authorities and be paid in a different way. The amount of the budget to be allocated to regional health authorities should be negotiated between the provincial government and the Alberta Medical Association in consultation with regional health authorities. Expansion of this model could be based on critical success factors as well as acceptance by the regional health authorities and physicians involved.

- **Within the fee for service system, there should be an independent review of rules around physician billing.**

  Currently, there are a number of rules in place that act as a disincentive to the kind of integrated care many physicians would like to provide. This includes rules which prevent physicians from being paid unless they see a patient directly rather than talking to them by phone or providing remote consultations using telecommunications. The purpose of this review would be to remove rules that act as a disincentive to providing effective and efficient care for patients.

✓ **Encourage and empower health providers to explore and implement a number of different approaches to organizing and delivering health care services.**

A number of primary health care projects such as the Crowfoot Family Practice in Calgary, the Bassano Health Centre, the pilot project in Taber, or the Northeast Community Health Centre are good models. But they have been hampered by the fact they are pilot projects, there is a heavy burden of administration and "paperwork", and they do not have a stable, long-term source of funding. Yet they provide the kind of comprehensive care people want.

More needs to be done to open up opportunities for health providers to provide this type of care. Better incentives should be in place to encourage health care providers to work in the public system as well as in private or not-for-profit organizations. This would provide physicians and other health providers with more choices in where they work and more opportunity to expand the services they provide.

As noted in the section on re-configuring the system, different health providers should be able to form "care groups" and offer a range of health services to individuals and to health authorities. These organizations could be established on a corporate model and allow providers the option of providing a range of insured and uninsured services. This option would provide more flexibility for different providers to work together, provide comprehensive care, and meet people's needs.

8. Make quality the top priority for Alberta's health system. Set standards, measure results, and hold people accountable for achieving better outcomes in health.

The health system in Alberta has the potential to be among the very best in the world, attracting and retaining outstanding health providers who deliver quality health services in a timely manner. This should be the goal.

While health authorities and government currently work together in certain areas to set targets and measure outcomes, on the whole, it's fair to say that Alberta's health care system is not guided by the best information or evidence. It is difficult to answer basic questions about the impact of certain treatments or new ways of organizing and delivering health services. Information is often impossible to compare, out of date, or simply not available. Alberta's health system should focus on using the best research and information available to improve health outcomes. It should be based on a judicious combination of best practices and evidence-based decisions.

Consistent with that overall direction, the following recommendations are proposed.

✓ **Continue to support research through a variety of sources and organizations in order to foster an evidence-based health system.**

As a result of the Alberta Heritage Foundation for Medical Research and the expertise of Alberta's universities, the province is known across Canada as a leading centre for health and medical research. Continuing support for Alberta-based research should continue to be a priority not only to develop new treatments and discover new cures, but also to expand Alberta's expertise in a knowledge-based economy.

✓ **Establish a permanent, independent Outcomes Commission to assess outcomes, track results and report regularly to Albertans.**

When government and regional health authorities measure and assess their own outcomes and results, it can put them in a conflict of interest. Tracking and monitoring outcomes and providing regular reports to Albertans is an essential way of improving quality in health care.

A new Outcomes Commission should have a long-term funding commitment and provide regular reports to Albertans on outcomes in health. The Commission could replace the Health Utilization Commission or the Health Utilization Commission's mandate could be expanded and its name changed to reflect more emphasis on quality and outcomes rather than just utilization. The Commission should focus on quality, define what quality means in our health care system, develop benchmarks and assess outcomes.

Steps should be taken to ensure the Commission operates at arms length from government. It should have the same status and independence as the Auditor General and have the same ability to provide independent reports, reviews and advice. It should report to the Minister of Health and Wellness and the Minister should be required to table annual reports with the Legislative Assembly.

The Outcomes Commission should be responsible for:

- Monitoring outcomes and quality in the health system
- Establishing performance measures and monitoring progress in achieving targets, goals and objectives set by the province
- Receiving regular reports from regional health authorities and other organizations involved in delivery of care

- Supporting and encouraging health services research, including collecting data and making it available for research purposes
- Providing regular reports to the public on the quality and outcomes of Alberta's health care system
- Scanning for trends in health care utilization, quality and costs
- Identifying best practices and innovative approaches and acting as a clearinghouse for information for health providers, health authorities, researchers and the public
- Reviewing and monitoring issues related to patient safety
- Reviewing regional variations in utilization for various procedures and treatments
- Making recommendations to the Minister of Health and Wellness on areas for quality improvements.

9. Recognize and promote Alberta's health sector as a dynamic, powerful asset to the provincial economy.

Alberta's health system is viewed primarily as a cost centre consuming limited and vital tax dollars. It rarely is seen as a dynamic economic asset and a driving force in Alberta's economy. With new sources of revenue, expanded opportunities for organizing and delivering health services, and continuing investments in research and education, the health sector has the potential to add considerably to the province's economy and to enhance our reputation as a world-wide centre of research, expertise and leadership.

Specifically, the Council recommends the following:

✓ **Continue to support research under the Alberta Heritage Foundation for Medical Research and take steps to sustain Alberta's reputation as a leading centre for medical research**

Thanks to the Alberta Heritage Foundation for Medical Research and Alberta's universities, the province has established a solid reputation as a leading centre for health and medical research. Continuing support is essential in order to attract leading researchers to the province.

✓ **Maintain and enhance support for education programs for health providers and medical schools and provide stability in how Alberta's medical schools are funded**

A well-educated and highly skilled health workforce is essential. It is important to build on the success of Alberta's education programs for health professionals and expand the emphasis on research. Alberta's medical schools are the primary source of a continuing supply of physicians. Currently, there are difficulties with the way in which medical schools are funded. These issues should be addressed so there is a stable base of funding in place and medical faculties are able to attract leading physicians to their faculty.

✓ **Support the development of multi-disciplinary, integrated, provincial centres of health research**

Alberta has an opportunity to build on existing strengths and develop leading edge centres of health research in the province. This concept is included in a report outlining a health research strategy for Alberta[9] and deserves further support as a way of expanding Alberta's role as a leading research centre in Canada.

✓ **Identify and promote public/private partnership opportunities for expanding research support**

Alberta has developed a number of leading edge research and technology companies. We should capitalize on the opportunity to expand partnerships between these leading private sector research companies and the public health sector, including regional health authorities, universities, medical and other health faculties, the Alberta Heritage Foundation for Medical Research, and various research foundations. This is particularly important in terms of expanding the health sector's investment in and use of information technology.

✓ **Promote commercialization of new products and services developed through health and medical research initiatives.**

One of the key challenges of research activities is to follow through and achieve the full potential of new discoveries, products and services. In the health and medical field, this involves going through an extensive process of research, clinical trials, and approval processes before new treatments, especially drugs, can be brought to market and made available to the public. While these processes are essential to ensure that new treatments are safe and produce the desired results, every effort should be made to speed up the process so that patients have timely access to effective new treatments and that the commercial potential of these treatments is achieved.

[9] *A Health Research Strategy for Alberta.* Alberta Science and Research Authority, 2001

10. Establish a clear transition plan to drive the process of change, oversee implementation of recommendations, consider options, and monitor the impact.

Many of the Council's recommendations would result in fundamental changes in Alberta's health care system. People in the health system have been through considerable change and turmoil already and will be reluctant to embark on yet another course of change unless clear goals are set and an orderly plan for transition is implemented and managed.

Because of the scope and complexity of putting this kind of transition plan in place, Council strongly urges government to designate an individual responsible for overseeing and driving the transition process. Work on this plan is a huge task that goes well beyond the day to day responsibilities of the Ministry of Health and Wellness. The individual selected for this task should be credible, independent, and well respected, with an understanding of the health system and an ability to drive change. Specific timelines should be established and the individual's work should be complete within a set timeline.

Specifically, this individual would be responsible for:

- fleshing out the details of how a number of reforms could be implemented
- coordinating further studies and developing an Alberta approach to funding health services based on options suggested by Council
- preparing and managing a detailed transition plan
- managing public expectations and educating the public on what changes will be made, when and what to expect as a result
- identifying and addressing barriers to implementation including legislation and regulations, labour codes and professional legislation, union agreements and conflicting policies among ministries
- ensuring that the system functions adequately and effectively through the transition phase
- managing and reporting progress on implementation of alternative payment plans for physicians.

The transition plan and key components should be approved by government and made public. The designated individual should report regularly to Albertans on the progress of health care reform. In terms of accountability, Council suggests that the individual should report to the Minister of Health and Wellness and the Premier.

Concluding comments

This report is about fundamental change to sustain Alberta's health system.

It's about opening up the system to new approaches rather than rationing health services.

It's about using every dollar to maximum benefit and finding better ways of paying for the health services people need and expect.

It's about putting patients first, providing people with guaranteed access to the services they need, and putting better incentives in place for individuals, health providers and health authorities.

It's about an unrelenting drive for quality and getting better outcomes.

It's about making the health sector a powerful asset in Alberta's economy.

And perhaps most important, it's about encouraging people to stay healthy.

Taken together, the package of recommendations in this report will address many of the issues of concern to Albertans today and provide a solid base for the future.

As we said at the outset, this report is not about short-term solutions or quick fixes. Instead, it provides a comprehensive approach to tackle many of today's problems in the health system and build a sound foundation for the future.

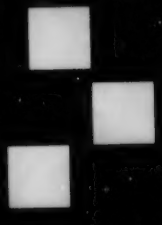
The challenge now is, "can we do it?" Are physicians, nurses and other providers working in the health system ready and willing to work together to explore the various options and implement comprehensive change? Are Albertans willing, once again, to lead the way in making bold changes? Are we willing to say the status quo simply is not good enough and we can and must do better?

As Council members, we believe health care providers and Albertans are ready ... ready to work together to reform and sustain Alberta's health care system. We have a unique opportunity to revitalize the health care system and make sure it serves not only our needs today but the needs of generations of Albertans to come. We believe our recommendations can do just that - revitalize the health system and address many of today's most pressing problems.

However, we must also end with a word of caution. We believe our recommendations are consistent with the spirit and intent of the Canada Health Act. At the same time, if actions are not taken to make changes in critical areas and sustain the health system, it is highly likely that pressures will mount to look for new options outside the limitations of the Canada Health Act. That may not be our preference, but we also acknowledge that Albertans and Canadians will not accept continued rationing of health services, long waiting times, and denied access to new treatments and technology available elsewhere. The challenge is ours to meet.

We trust that the ideas and recommendations included in our report will help guide decisions about the future of Alberta's health system. Our goal should be nothing short of building one of the best health care systems in the world. Once again, Albertans have an opportunity to build a unique Alberta solution and lead the rest of Canada in establishing a sustainable health care system for the 21st century.

Appendices



Presentations and submissions

Presentations and Submissions

Action on Smoking and Health

Alberta Alliance on Mental Illness and Mental Health

Alberta Association of Registered Nurses

Alberta Cancer Board

Alberta Council on Aging

Alberta Health and Wellness

Alberta Heritage Foundation for Medical Research

Alberta Lung Association

Alberta Medical Association

Alberta Mental Health Board

Alberta Nursing Education Administrators (ANEA)

Alberta Pro-Life Association

Alberta Psychiatric Association

Alberta Research Council

Alberta Science and Research Authority (ASRA)

Alberta Tobacco Reduction Alliance

alberta we//net

Baker, Hal

Belle, James

Belseck, Nellie

Bethany Care Centre

Benoit, Leon - MP for Lakeland

Boothe, Paul

C.D. Howe Institute

Canadian Complementary Medical Association

Canadian Life and Health Insurance Association Inc.

Carpay, John - Canadian Taxpayers Federation

Cenaiko, Harvey - Chairman of MLA Review of Ambulance Service Delivery

Child and Adolescent Services Association (CASA)

Chinook Health Region

College of Licensed Practical Nurses of Alberta

College of Physicians and Surgeons of Alberta

Council of CEOs of Regional Health Authorities

Council of Chairs of Regional Health Authorities

Crowfoot Village Family Medicine

Davis, Jack - CEO of Calgary Health Region

Donaldson, Cam

Duncan, Don

Evans, Iris - Minister of Alberta Children's Services

Faculty of Medicine and Dentistry - U of A

Faculty of Pharmaceutical Sciences - U of A

Faculty of Rehabilitation Medicine - U o f A

Fong, Chen

Friends of Medicare

Gimbel, Howard

Golka, L.J.

Grant, Eileen - Representative of the not-for-profit sector

Haiste-Shields, Jan

Hatcher, Peter

Health Care Unions

Hjertqvist, Johan

Horner, Jean

Huang, Peter

Institute of Health Economics

Johnson, LeRoy - MLA for Wetaskiwin-Camrose

Kirby, Michael and members of the Standing Sentate Committee on Social Affairs, Science and Technology

Kinkaide, Perry - Kinkaide Enterprises Inc.

Mar, Gary - Minister of Alberta Health and Wellness

Menon, Devidas

Merrifield, Rob - MP for Yellowhead

Metro Edmonton Health Industry Association

Miller, Stephen

Modry, Dennis

Morison, Nicholas - Vein Clinic

Noseworthy, Tom

Office of the Auditor General of Alberta

O'Neill, Mary - Chair of Standing Policy Committee on Health and Community Living

Palmer, Ginette

Percy, Michael

Pettit, Rita

Pfizer Canada Inc.

Provincial Health Authorities of Alberta

Provincial Health Ethics Network

Romanow, Roy - Commissioner, Commission for the Future of Health Care in Canada

Russell, Dalton - CEO of Mistahia Regional Health Authority

Sayeed, A.R.

Shapiro, Johnathon

Snider, Earle

Temple, Wally

Toop, David

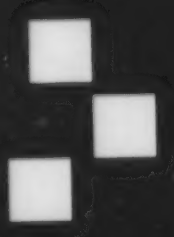
Vogelzang, John - CEO of David Thompson Health Region

Weatherill, Sheila - CEO of Capital Health Region

Westman, Erin

Westview Regional Health Authority

Wilson, Donald E.



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Context papers

Context papers:

How does Alberta's health system work?

How does Alberta's health system work?

This is one of a series of background papers prepared for the Premier's Advisory Council on Health. The background papers provide factual information on a variety of topics and pose questions for further consideration. They are intended to set a context for discussion and exploration by the Council and other interested Albertans. Copies of the background papers are available on the website for the Premier's Council at www.premiersadvisory.com and also by contacting the Council's offices at 780 – 421-1848.

What's the issue?

A lot of people are confused about how Alberta's health system works. People ask questions like: Who decides what services are available? Does the health system work well? Is it efficient? How do we know if it is producing the results people want and expect?

There are a lot of players in Alberta's health system – health authorities, doctors, nurses and other health providers, the federal government and the provincial government, in addition to community health councils, health-related organizations, and thousands of volunteers.

What is the responsibility of the various players and who is accountable for what?

What do we know?

Who is responsible?

Responsibility for different aspects of the health system is set out in a number of different vehicles including legislation, policies, and professional legislation.

The following is a summary of the key responsibilities of a variety of different individuals and organizations in health.

Individual Albertans

- Are responsible for their own health
- Ensure the health and safety of their family
- Educate themselves about ways of staying healthy
- Use the health system in a responsible manner
- Assist health providers by providing information about their health
- Educate themselves about health services and how to use those services appropriately
- Follow instructions for diagnostic tests and treatments
- Register with Alberta Health Care Insurance Plan, if eligible, and pay premiums.

First and foremost, individuals have responsibility for their own health. They have the right to make their own health decisions and to have the information they need to guide their decisions. They also have the right to expect that the privacy of their personal health information will be safeguarded.

Federal government

- Provides funding to the provinces through the Canada Health and Social Transfer to support health services, with the understanding that the provinces will follow the principles of the Canada Health Act
- Manages health services on federal lands and Indian reserves
- Funds health services for selected groups such as the military, veterans, immigrants and registered Indians
- Addresses national health concerns by providing grants to provinces or community groups

- Sponsors health research
- Manages the Canada Health Act
- Promotes good health, disease prevention and health education
- Provides regulatory authority and framework for drugs, medical devices, safety devices and dangerous substances.

The federal government works with the provinces to address health issues on a national basis and to set priorities for cooperative action across the country.

Provincial government

- Has primary responsibility for the health system in Alberta
- Sets provincial direction, policies, strategies and standards for health and wellness and ensures there is coordination among regional and provincial health authorities, public and private organizations
- Sets priorities based on health needs
- Determines the scope of the financial, capital and human resources required
- Allocates resources to health authorities and some health providers such as physicians, dental surgeons, chiropractors, podiatrists and optometrists. Support also is provided for research through the Alberta Heritage Foundation for Medical Research and the two faculties of medicine at the University of Alberta and the University of Calgary.
- Promotes wellness and works to prevent disease and injury
- Ensures the delivery of quality health services by:
    - Establishing health authorities to deliver health services
    - Ensuring that Albertans understand what services are available and where to turn if there are problems
    - Ensuring that emerging health issues are addressed and new technology is examined
    - Operating a central communicable disease control program, the Alberta Aids to Daily Living program and the air ambulance program
    - Registering Albertans for health insurance benefits
    - Paying physicians and other health providers for their services
    - Working with other organizations to ensure that Alberta has an adequate supply of health professionals.
- Measures and reports on the performance of the health system through collecting, managing and monitoring related health information. The province also is responsible for protecting the privacy of individuals' personal health information.
- Enables Albertans to make informed decisions about their health.

The Minister of Health and Wellness and his department are primarily responsible for fulfilling the provincial government's responsibilities in health. Alberta Health and Wellness works with a number of other ministries and government agencies that also have responsibilities in health including: responsibility for protecting people who live in health facilities, protecting children and promoting healthy beginnings, building and maintaining hospitals, planning and delivering seniors' policies and programs, providing health education, providing education and treatment related to alcohol, drugs and gambling addictions, and managing workers' compensation.

Regional health authorities

- Have primary responsibility for delivering health care services to Albertans. They run hospitals, health centres and some long term care facilities, provide home care, prevention and promotion programs and community programs. They arrange for physicians' services, hire nurses, lab technicians and the full range of health care providers. They inspect restaurants, investigate environmental problems affecting health, and work with others to address health issues in their community. Many regional health authorities also have established foundations to assist in raising funds from community members to support health initiatives and equipment.
- Promote and protect the health of people in their region, including actions to prevent disease and injury

- Assess the health needs of people in their region
- Set priorities for health services in their region and allocate resources
- Ensure reasonable access to quality health services in their region
- Provide health services that respond to people's needs and ensure that the various services are integrated.

Alberta has seventeen regional health authorities. They are accountable to the Minister of Health and Wellness. Until the fall of 2001, all members of regional health authority boards were appointed by the Minister. As of this fall, two thirds of board members will be elected.

Alberta Mental Health Board

- Assesses the mental health of Albertans
- Determines priorities for mental health services
- Allocates resources
- Develops and monitors standards and performance in the delivery of mental health services
- Delivers and coordinates mental health services
- Carries out and promotes mental health research
- Promotes and advocates mental health services that respond to the needs of individuals and communities and supports the integration of services and facilities.

The Alberta Mental Health Board delivers mental health services through community clinics and contracted agencies. It is responsible for the Claresholm and Raymond Care Centres and the Alberta Hospitals in Edmonton and Ponoka. It also provides forensic psychiatry services for Alberta, Canada's north and the federal government. Mental health services are also provided by regional health authorities and by individual physicians and psychologists. Arrangements are underway for regional health authorities to provide some community mental health services under contract to the Alberta Mental Health Board.

The Alberta Mental Health Board is accountable to the Minister of Health and Wellness. All members of the Board are appointed.

Alberta Cancer Board

- Establishes and operates provincial cancer hospitals and outpatient facilities for:
  - Preventing, detecting and diagnosing cancer
  - Treating and caring for cancer patients
  - Conducting cancer research.
- Works with regional health authorities to provide cancer treatment and coordinate cancer services
- Operates outpatient cancer clinics across the province, collectively called the Community Cancer Network, to link cancer centres with regional and community facilities
- Operates the Alberta Program for the Early Detection of Cancer
- Operates a Cancer Registry to help monitor trends in cancer, develop effective cancer screening programs, and implement prevention strategies.

The Alberta Cancer Board is accountable to the Minister of Health and Wellness. All members of the Board are appointed.

Health professionals

- Provide direct health services to Albertans
- Provide advice, care and treatment
- Educate their patients
- Represent and act in their patients' best interests.

Health professionals cover a wide spectrum of people including physicians, nurses, physiotherapists, rehabilitation therapists, optometrists, dentists, pharmacists, dietitians, psychologists, chiropractors, and others. Health authorities employ most of the health professionals in the province, other than physicians and other fee for service health professionals. Many physicians and other health professionals (e.g. dentists, optometrists, and chiropractors) operate their own private practices. Physicians and some health providers such as optometrists, chiropractors, and podiatrists are funded all or in part by the province through the Alberta Health Care Insurance Plan.

Most physicians are paid on a fee for service basis through an agreement between the provincial government and the Alberta Medical Association. Many work in regional health authority hospitals and are on the medical staff of the health authority. Many also have offices in the community. These physicians admit patients into hospitals, treat and refer patients to specialists and other health providers, order lab and other diagnostic tests. They have a significant impact on how hospitals are used and how health authority resources are spent.

Health professionals are accountable to:

- Their professional organization – the body that sets professional standards, licenses members, and makes sure professional standards are met
- Their employer or the organization they have a contract with
- Their hospital if they are on the medical staff.

For those who bill the Alberta Health Care Insurance Plan, they have to answer to the Minister of Health and Wellness for their billings. Aside from that, health professionals are not accountable to the Minister.

How does the system work?

In simple terms, the Minister of Health and Wellness and his department are responsible for setting overall direction and provincial policies. Health authorities are expected to develop business plans consistent with the overall direction set by the province, to track results, and report regularly on key performance measures.

On a day to day basis, most decisions about how health services are organized and delivered are made by the management of health authorities. Boards of regional health authorities set priorities, approve plans, and set budgets for their region. Within that framework, CEOs and managers make decisions about how to implement plans and deliver health services. They address problems in the system, hire staff, answer questions from the public and the media, monitor budgets, influence provincial policies, decide what services are needed and how and where they will be provided. They monitor the overall health of people in the region, keep track of waiting lists and other key indicators, assess where there are gaps in services, and decide how to fill those gaps. They also initiate plans and actions to promote and protect health and prevent illness and injuries.

Physicians and other health providers are responsible for direct care. Physicians diagnose and treat illnesses and injuries, work with other providers, and provide follow-up care. Nurses provide direct care to patients in hospitals, clinics, home care and community programs. Other health professionals provide services related to their professional training.

Who makes decisions?

The provincial government makes decisions about:

- Provincial policies, directions, and business plans
- How much money the province spends on health and how much is allocated to each health authority
- Funding for construction and renovation of facilities like hospitals, long term care facilities, clinics, etc. (facilities operated under the Hospitals Act, the Nursing Homes Act, the Public Health Act and the Mental Health Act)

- Funding for province-wide programs and initiatives – e.g. breast cancer screening programs, initiatives to reduce smoking, heart health programs, children's health, etc.
- New drugs to be supported by provincial funding
- Funding for physicians.

Health authorities make decisions about:

- Health services and programs to be provided
- Annual budgets and priorities – how much will be spent on various programs and services
- Staffing levels, hiring, salaries and benefits for health providers employed in the region
- Operation of facilities like hospitals, clinics or community health centres
- Numbers of hospital beds, surgeries, and treatments provided.

Physicians make decisions about:

- Diagnosis and treatment of their patients
- Referral of their patients to lab and diagnostic tests and specialists
- Priority of patients for access to surgeries – i.e. they decide whether their patients need surgery on an urgent basis or can wait while others with higher priority needs are treated
- Follow-up care needed by their patients – e.g. home care, rehabilitation therapy, etc.

What concerns have been raised?

The following are some of the questions and concerns that have been raised.

- There's no way of knowing if the system is efficient. When health authorities set and spend their budgets, there's no way of answering questions like: Is the system efficient? Is the health authority making the best use of the resources it has?
- Health authorities are accountable for how they spend funds allocated from the province, but they're not as accountable for the results they achieve in improving health. How do we ensure we're getting good value for the money spent?
- Decisions aren't always based on sound evidence – sometimes information is lacking and sometimes other factors influence decisions.
- The Auditor General has provided several recommendations for improving systems of governance and accountability. The Auditor General reports have indicated that appropriate controls are not always in place, there are weaknesses in business planning and budgeting, some boards and senior managers are more capable than others in providing direction and decisions for their region, and there are gaps in performance reporting (plans and results are not linked).
- How will accountability of regional health authority boards change now that the majority of members are elected?
- Who are physicians accountable to and how can their relationship to regional health authorities be clarified and improved?
- The health system is largely an unregulated monopoly because government:
  - Defines what constitutes medically necessary services
  - Pays for all services provided
  - Forbids private insurance for these services
  - Prevents people from obtaining these services outside government-approved channels
  - Directly or indirectly administers and governs care
  - Is responsible for defining, collecting and reviewing information on its own performance.

  Are there ways of "unbundling" or opening up the system and would this result in better information, more efficiency and better outcomes?

Questions to consider

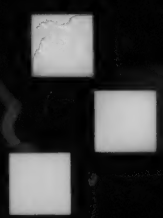
- How can health authorities and health professionals be more accountable for the outcomes they achieve?
- How do we assess whether the health system is efficient and productive?
- Are there ways the system can be streamlined?
- What changes can or should be made in the relationship between health authorities and physicians?
- What role should the province play in setting direction for health in the province? Should they have more control or less control over policies and decisions of health authorities?
- Who should develop health strategies and how should those strategies be tied to decisions about allocating resources?

Sources of Information:

"Who is accountable in health? Roles and responsibilities in Alberta's health system", Alberta Health and Wellness, August 1999

Annual Reports of Alberta's Auditor General

Presentation from the Auditor General to the Premier's Advisory Council on Health



Context papers:

How long do people wait?

How long do people wait?

This is one of a series of background papers prepared for the Premier's Advisory Council on Health. The background papers provide factual information on a variety of topics and pose questions for further consideration. They are intended to set a context for discussion and exploration by the Council and other interested Albertans. Copies of the background papers are available on the website for the Premier's Council at www.premiersadvisory.com and also by contacting the Council's offices at 780 – 421-1848.

What's the issue?

In recent years, Albertans have become more concerned with access to the health system, in particular the length of time people sometimes wait for major surgeries and treatments, especially cancer treatments, heart surgeries, joint replacements and MRIs. Concerns also have been expressed about how long people wait in emergency rooms before they're admitted to hospital, how long they wait until they can move into a long term care centre or how much time it takes to get to see a physician.

What are the average waiting times for these services? How do Alberta's waiting times compare with acceptable standards or other provinces? Are the waiting times acceptable and if not, what needs to be done?

What do we know?

Although we frequently hear stories of long waiting times, the reality is, we don't have reliable and consistent information on waiting times. Alberta Health and Wellness has worked with regional health authorities in recent years to address this problem and develop more timely and consistent information. However, there is little information that would allow us to compare Alberta with other provinces because of differences in how waiting times are defined and measured.

The following is the latest information available from Alberta Health and Wellness on waiting times for key services and treatments.

Cancer treatment – as of June 30, 2001

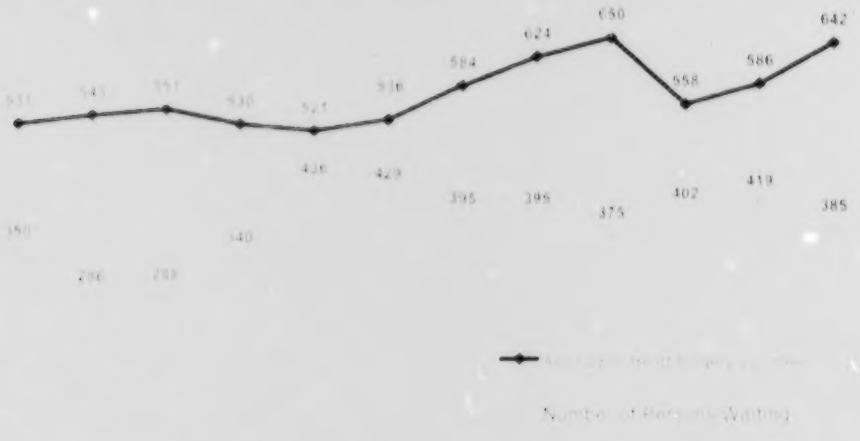
- On average, people wait 2 to 6.5 weeks to access radiotherapy for treating breast cancer and 4.5 to 5 weeks for access to chemotherapy.
- For prostate cancer, the waiting times for access to radiotherapy range from 7 to 9.5 weeks. Waiting times for access to chemotherapy range from 6 to 10 weeks.

Cardiac surgeries – as of March 31, 2001

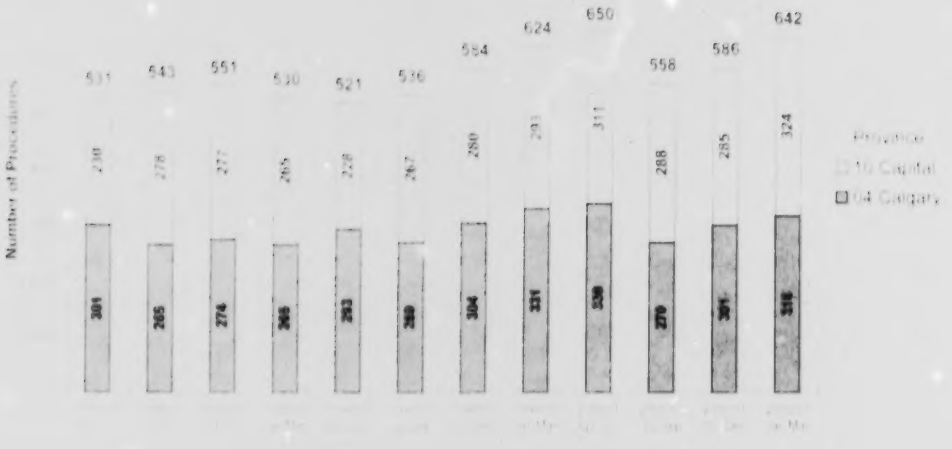
- Open heart surgeries are provided in two regions: the Capital Health Authority and the Calgary Health Region. Because of Alberta's growing and aging population, the referral rate for open heart surgery has increased in recent years. Commonly known as "bypass" surgery, the procedure opens arteries that have been plugged and improves blood flow, reduces symptoms for patients, and improves their quality of life.
- The provincial target is to reduce average waiting times for open heart surgery to:
  - one week for urgent inpatients
  - 2 weeks for urgent outpatients
  - 6 weeks for planned outpatients.
- At the end of March 2001, 385 adults were waiting for open heart surgery, a 2.5% decrease from March 2000.
- For the fiscal year 2000/01, surgery volumes were up 8% compared with the previous year.
- Surgical volumes were down from July to September 2000 due to shortages of staff.

- Median waiting times for January to March 2001 varied from 11 days for urgent inpatients to 15-18 weeks for urgent outpatients and 15-19 weeks for planned outpatients.
- Only two urgent outpatients (the targets for 2000/01) have not been met.

Alberta - Adult Open Heart Surgery Volumes and Number of Persons Waiting

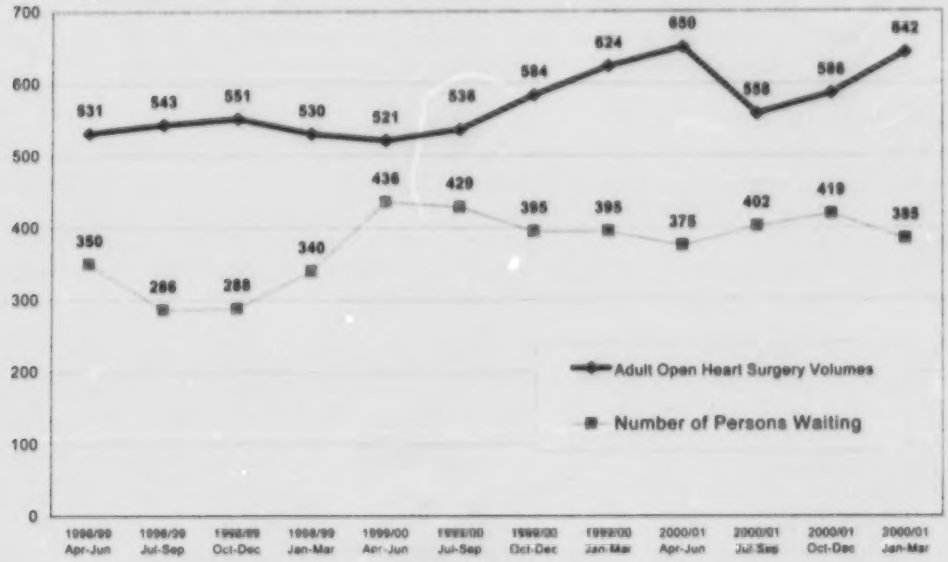


Alberta - Adult Open Heart Surgery Volumes
By Region, by Quarter



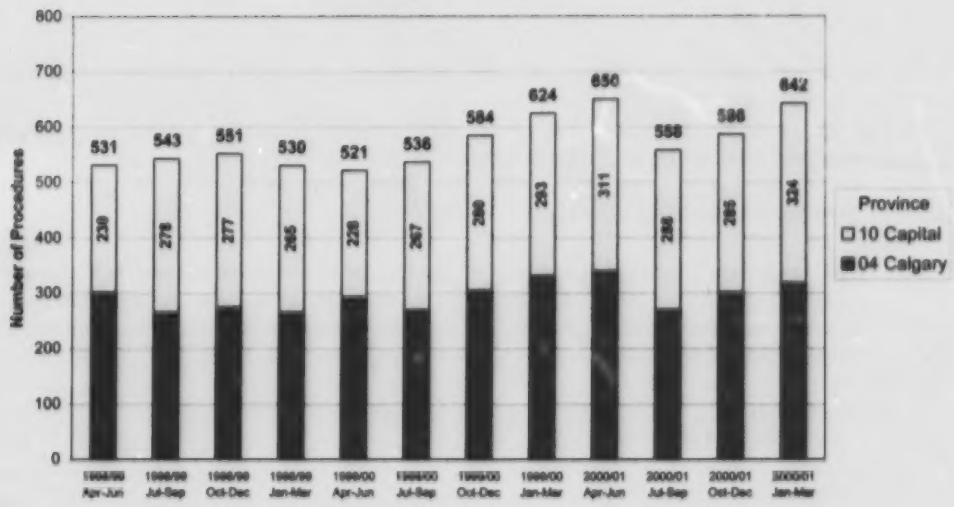
- Median waiting times for January to March 2001 varied from 11 days for urgent inpatients to 15-18 weeks for urgent outpatients and 15-19 weeks for planned outpatients.
- Aside from urgent inpatients, the targets for 2000-01 have not been met.

Alberta - Adult Open Heart Surgery Volumes and Number of Persons Waiting



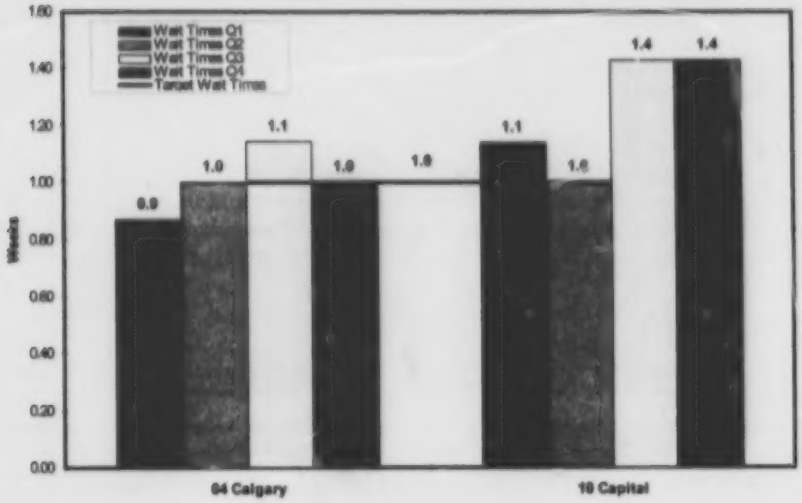
Source: Alberta Health and Wellness, Standard and Measures, Quarterly Reporting

Alberta - Adult Open Heart Surgery Volumes
By Region, by Quarter



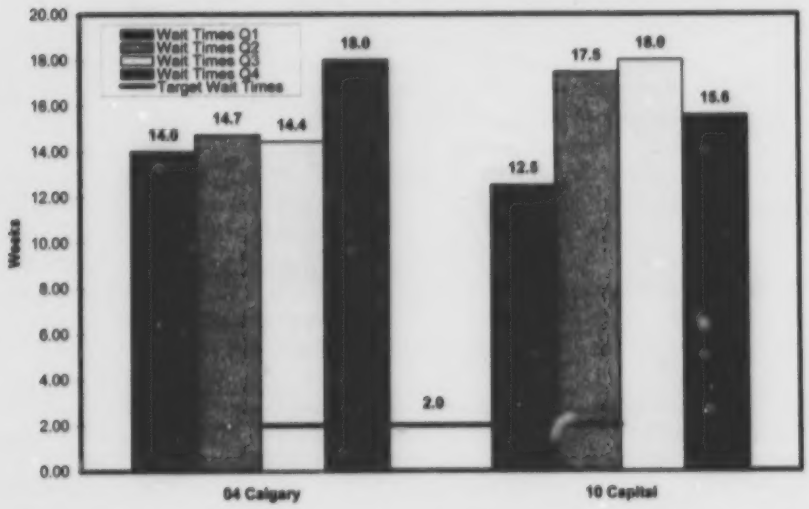
Source: Alberta Health and Wellness, Standard and Measures, Quarterly Reporting

Alberta - Adult Open Heart Surgery
Median Waiting Times (weeks) by Service RHA for Apr 2000 through Mar 2001
By Priority Level - 2 Urgent Inpatient



Source: Alberta Health and Wellness, Standard and Measures, Quarterly Reporting

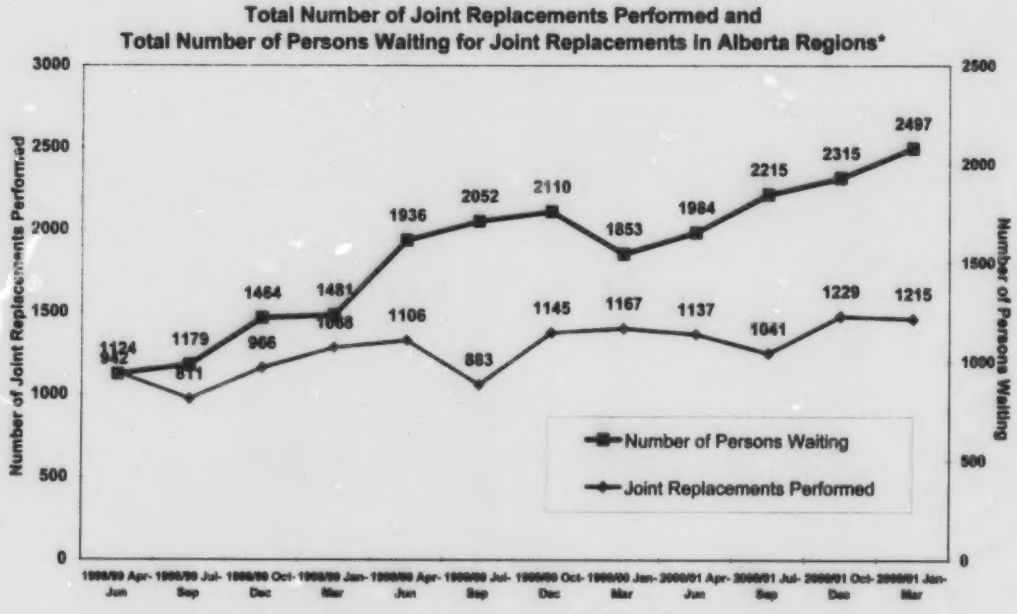
Alberta - Adult Open Heart Surgery
Median Waiting Times (weeks) by Service RHA for Apr 2000 through Mar 2001
By Priority Level - 3 Urgent Outpatient



Source: Alberta Health and Wellness, Standard and Measures, Quarterly Reporting

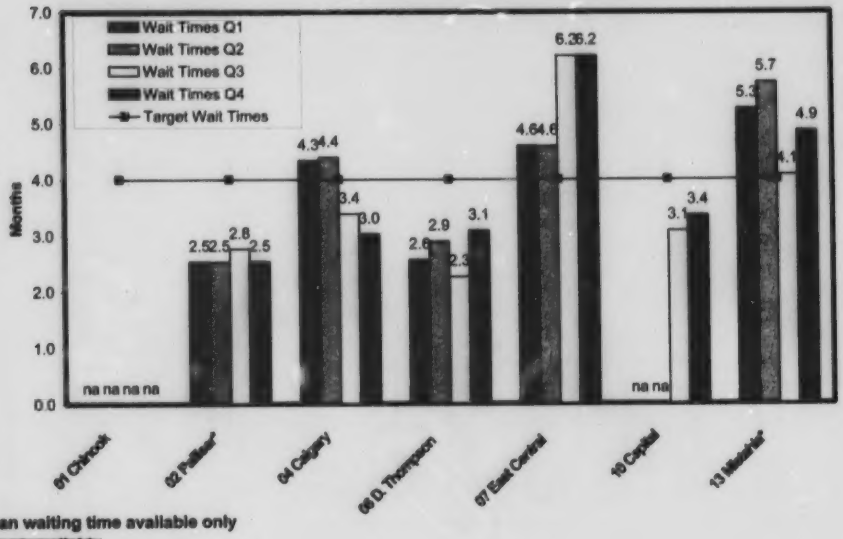
Joint replacements (hips and knees) – as of March 31, 2001

- Seven regional health authorities perform hip and knee replacements:
  - Chinook (Lethbridge)
  - Palliser (Medicine Hat)
  - Calgary
  - David Thompson (Red Deer)
  - East Central (Camrose)
  - Capital (Edmonton)
  - Mistahia (Grande Prairie).
- Over the past 10 – 20 years, hip and knee replacement surgery has increased at rates higher than for most other surgeries. This is due to an aging population, the incidence of arthritis in older people and increasingly safe and effective surgical procedures. The volume of joint replacements is affected by the cost of the artificial joints; some regions have had to limit the volume of surgeries they can do within the scope of their budgets.
- The provincial target is to reduce the average waiting time to 4 months for non-urgent surgeries. Emergency joint replacements are typically done within 48 hours.
- At the end of March 2001, there were 2497 people waiting for hip and knee replacements, up 33% from the previous year.
- During the fiscal year 2000/01, 4622 replacements were performed by the seven regions compared with 4301 the previous year, an increase of 7%.
- Average waiting time is 2.5 to 6.2 months (based on reports from six of the seven regions).



*RHAs included: Palliser, CHR, East Central, CHA, Mistahia from Q1 9899; Chinook and DTHR from Q1 99/00

Hip/Knee Replacement:
Median Waiting Times (months) by Service RHA for April 2000 through March 2001

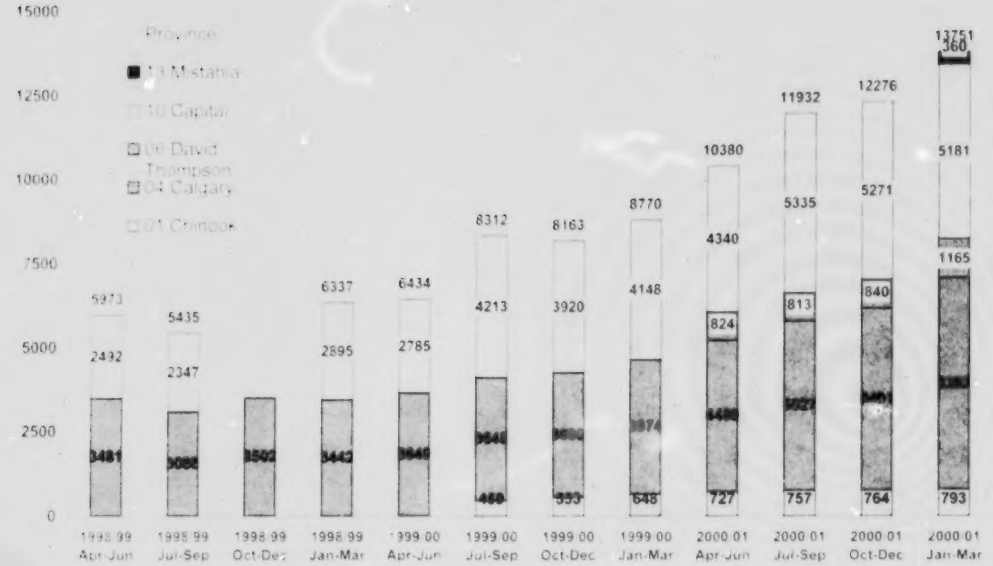


*** Mean waiting time available only**
na - not available

Magnetic Resonance Imaging (MRI) – as of March 31, 2001

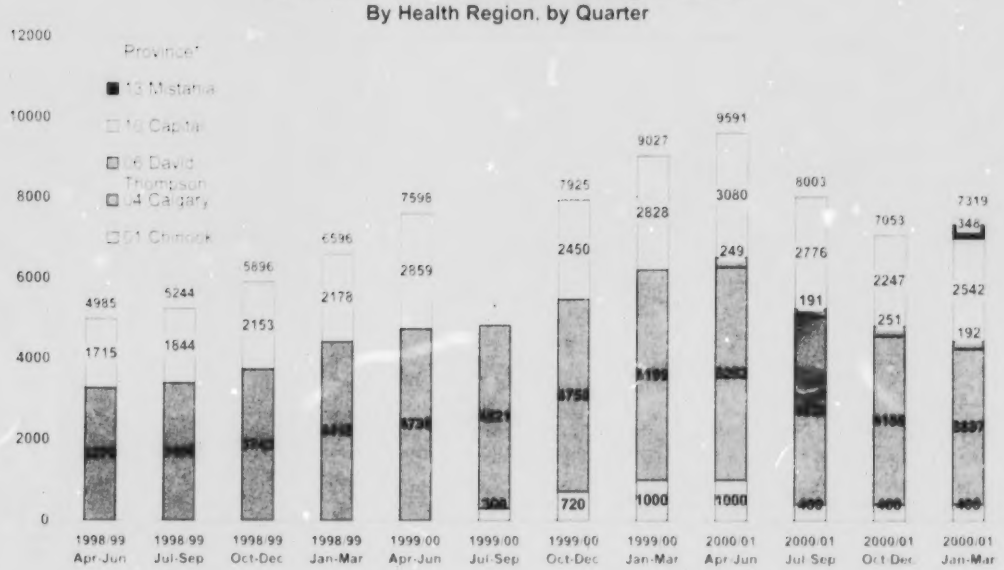
- MRI is a diagnostic test that provides high-resolution pictures of the structure of any organ or area of the body. As the range of conditions that can potentially be diagnosed by MRI has expanded, the existing capacity for MRI service across the province has not kept pace with demand. Increased waiting lists and waiting times are a concern.
- MRIs are offered in five regions: Capital Health, Calgary, Chinook (Lethbridge), David Thompson (Red Deer) and Mistahia (Grande Prairie). The Alberta Cancer Board also provides MRIs, but that data is not included. MRIs also are provided in the private sector at a cost to individual Albertans.
- At the end of March 2001, there were 7319 people waiting for public MRIs, a 19% decrease from the 9027 people waiting in March 2000.
- During the fiscal year 2000/01, 48,339 MRIs were performed by regional health authorities compared with 31,679 in the previous year, an increase of 53%. In Capital Health and Calgary Health Region, this includes some MRIs contracted from private MRI providers.
- Inpatient MRIs were performed within 24 – 48 hours.
- In January to March 2001, average waiting times for outpatients ranged from 2 weeks to 13 weeks, depending on how urgent the case was.
- Additional MRIs have been funded in Edmonton (3 units), Calgary (3 units), Medicine Hat (1 unit) and Grande Prairie (1 unit).
- In April 2001, the provincial government announced plans to double the number of MRIs performed in the province. A target of 24 scans per thousand people has been set, the highest rate in the country. That compares with the 1999/00 scan rate of 10.4 scans per thousand people. The 24 per thousand scan rate means 73,000 MRI scans would be done per year.
- At the end of December 2000, there were seven public MRIs operating in Alberta. By July 2001, nine public MRIs were operating in Alberta. Eight additional MRIs will be in operation by the fall of 2001.
- Additional funding also has been provided to increase the number of MRI technicians trained at NAIT.

Province - Number of MRI Examinations Completed
By Health Region, By Quarter



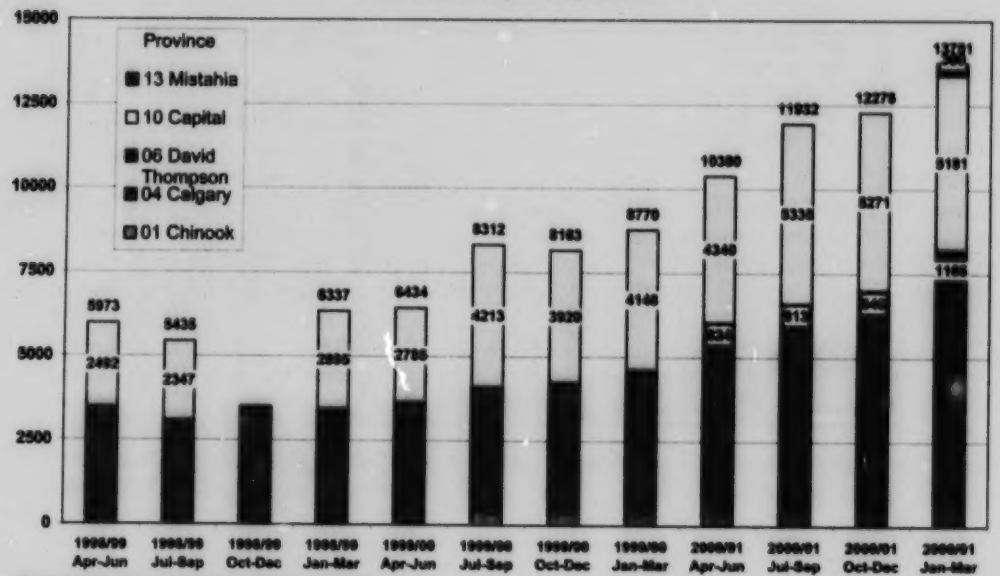
* Capital Health data not available for Quarter 2, 1998/99.
Source: Alberta Health and Wellness, Standard and Measures, Quarterly Reporting

Province - Number of Persons Waiting for an MRI
By Health Region, by Quarter



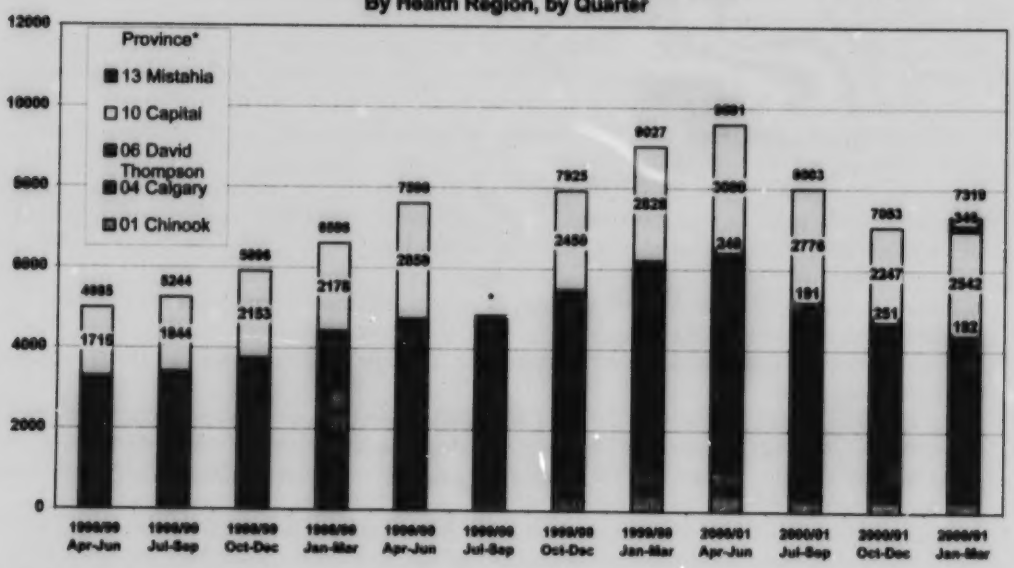
* Capital Health data not available for Quarter 2, 1998/99.
Source: Alberta Health and Wellness, Standard and Measures, Quarterly Reporting

Province - Number of MRI Examinations Completed
By Health Region, By Quarter



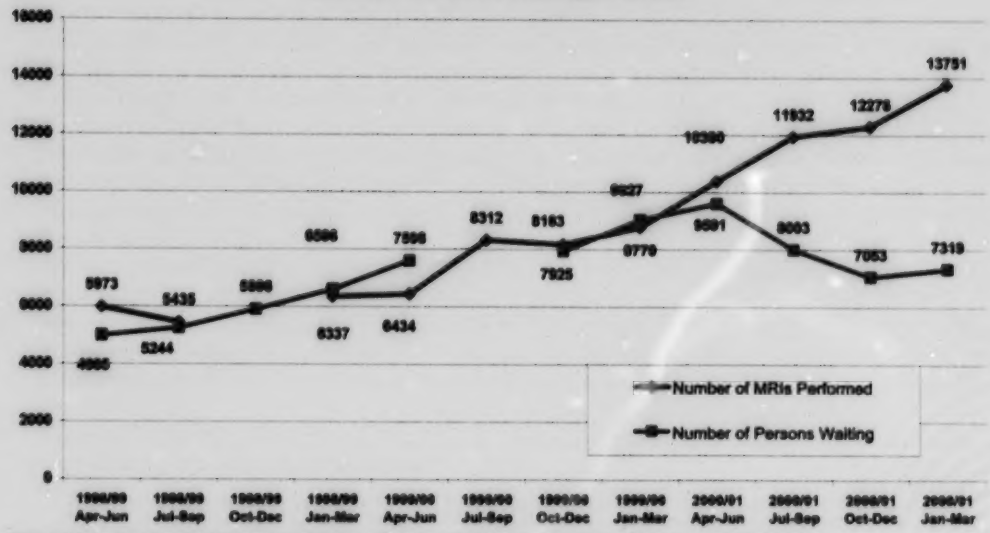
* Capital Health data not available for Quarter 3, 1998/99.
Source: Alberta Health and Wellness, Standard and Measures, Quarterly Reporting

Province - Number of Persons Waiting for an MRI
By Health Region, by Quarter



* Capital Health data not available for Quarter 2, 1999/00.
Source: Alberta Health and Wellness, Standard and Measures, Quarterly Reporting

Province - Number of MRI Examinations Completed and Number of Persons Waiting for an MRI

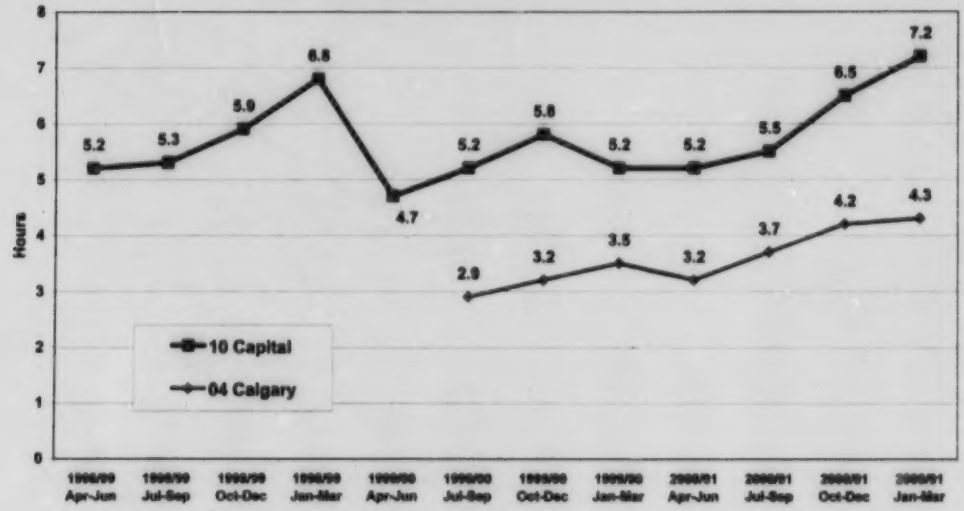


*Data includes: Calgary, Capital and Chinook Regions (99/00 Q2 and after), David Thompson (00/01, Q1 and after), Misiahia (00/01, Q4 and after). Excludes Qtr 3 98/99 and Qtr 2 99/00 due to incomplete data.
Source: Alberta Health and Wellness, Standard and Measures, Quarterly Reporting

Waiting in emergency for admission to a hospital bed – Calgary and Capital Regions, as of March 31, 2001

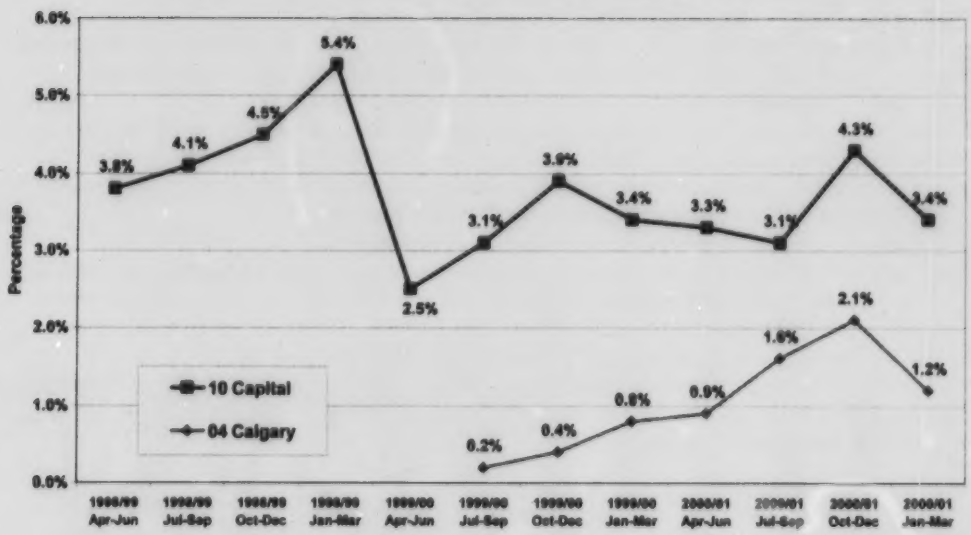
- The time people have to wait in emergency until they are admitted to hospital is an indication of how efficient the system is and the availability of hospital beds. When no hospital beds are available, patients have to wait in emergency. This is distressing to patients and puts added strain on emergency departments and staff. It can also result in ambulances being diverted to other hospitals if an emergency department becomes too busy to handle new emergency cases.
- Across Canada, this is primarily an issue in larger urban hospitals. Waiting times are often the longest during winter months, when the influenza season increases the number of visits to emergency departments and the need for hospital beds. It can also occur when there aren't enough long term care beds and people are forced to wait in hospital until space is available.
- Information is provided by the Calgary and Capital Health Regions.
- From January to March 2001, the average time people waited to be moved to an inpatient bed was 7.2 hours for Capital Health and 4.3 hours for Calgary Health Region. This is a slight increase over averages for the same period in the previous year (5.2 hours and 3.5 hours). Reasons for the increase include increased ER volumes, shortages of inpatient beds, and staff shortages.
- For January to March 2001, the percentage of people who waited more than 24 hours to be moved from emergency to an inpatient bed was 3.4% for Capital Health and 1.2% for Calgary Health Region, similar to the same period last year.

Average Number of Hours Patients Waited in the Emergency Department
Capital and Calgary Health Regions



Source: Alberta Health and Wellness, Standard and Measures, Quarterly Reporting

Percentage of of Patients Designated as 'Admitted as Inpatient' Who Waited More than 24 Hours, Capital and Calgary Health Regions

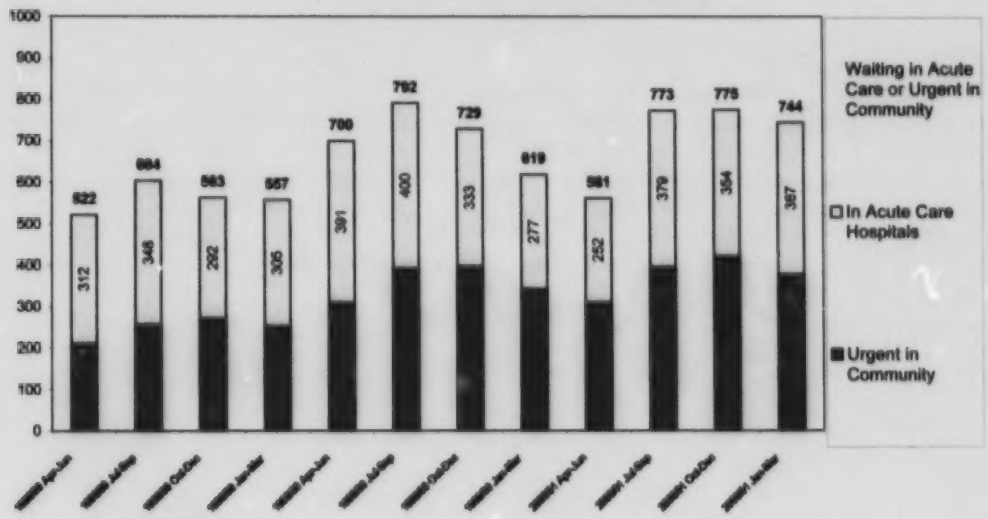


Source: Alberta Health and Wellness, Standard and Measures, Quarterly Reporting

Long term care – as of March 31, 2001

- When people are no longer able to remain in their own homes, they want to be placed in a long term care institution as quickly as possible. Sometimes people wait in hospital beds if there are no long term care spaces available. In other cases, they wait in the community. The more urgent needs are for people who are waiting in hospital beds or in the community, whose needs exceed the resources that are available from either home care or other community supports.
- A number of factors have contributed to growing waiting lists for long term care including: an aging population, aging facilities and limited beds available, and limits on the speed and extent of home care and other supportive community arrangements to take the place of long term care.
- At the end of March 2001, 744 people were waiting for placement in a long term care facility, up 20% from 619 in March 2000.
- 5918 people were placed in long term care facilities from April 2000 to March 2001 compared to 6047 in the previous year.
- Following the release of the provincial report on long term care (Broda Report), the province increased its investment in long term care facilities. In total, $172 million has been approved for long term care facilities across the province to expand current capacity, upgrade existing facilities and replace older faciltities.
- The provincial target is to reduce the number of people waiting urgently in the community or hospital for admission to a long term care facility.

Number of Persons Waiting for Long Term Care by Client Type and Total, In Alberta

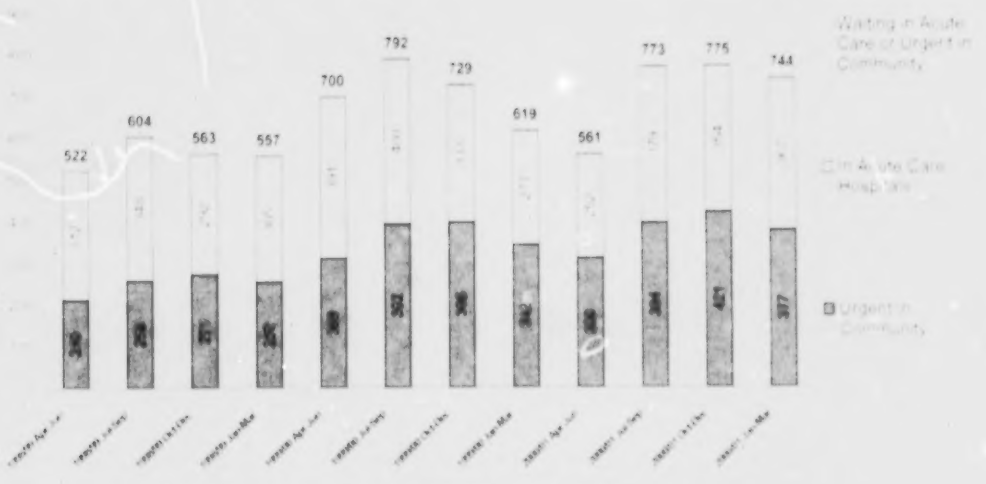


Source: Alberta Health and Wellness, Standard and Measures, Quarterly Reporting

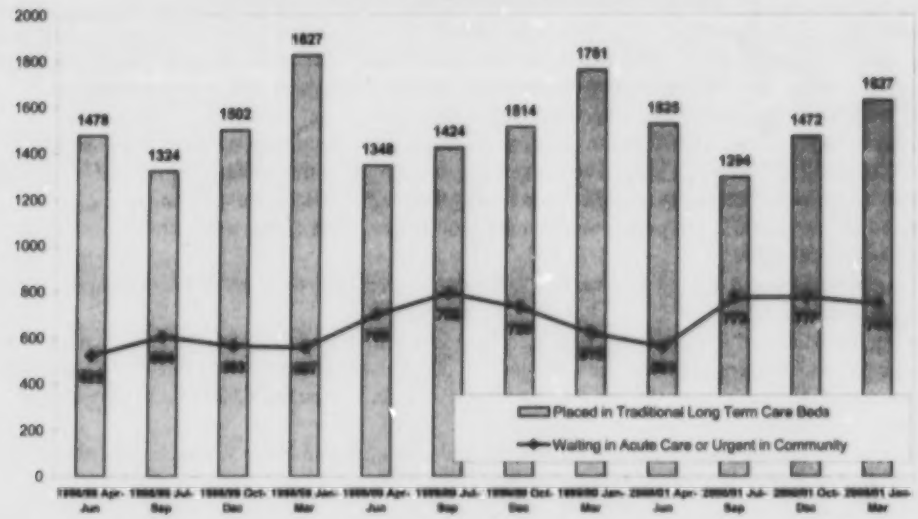
Long term care as of March 31, 2001

- When people are no longer able to remain in their own homes, they want to be placed in a long term care institution as quickly as possible. Sometimes people wait in hospital beds if there are no long term care spaces available. In other cases, they wait in the community. The more urgent needs are for people who are waiting in hospital beds or in the community, whose needs exceed the resources that are available from either home care or other community supports.
- A number of factors have contributed to growing waiting lists for long term care including: an aging population, aging facilities and limited beds available, and limits on the speed and extent of home care and other supportive community arrangements to take the place of long term care.
- At the end of March 2001, 744 people were waiting for placement in a long term care facility, up 20% from 619 in March 2000.
- 5918 people were placed in long term care facilities from April 2000 to March 2001 compared to 6047 in the previous year.
- Following the release of the provincial report on long term care (Broda Report), the province increased its investment in long term care facilities. In total, $172 million has been approved for long term care facilities across the province to expand current capacity, upgrade existing facilities and replace older facilities.
- The provincial target is to reduce the number of people waiting urgently in the community or hospital for admission to a long term care facility.

Number of Persons Waiting for Long Term Care by Client Type and Total, in Alberta



Number of Persons Placed in Long Term Care Versus Number of Persons Waiting for Long Term Care in Alberta



Source: Alberta Health and Wellness, Standard and Measures, Quarterly Reporting

Access to physicians

In the annual survey conducted by Alberta Health and Wellness in 2001, 47% of participants who said they had difficulty accessing health services said it was difficult to access the services of general practitioners (41% in 2000) and 35% said it was difficult to access services of a specialist. The following chart summarizes how long people said they waited to see family physicians and specialists.

Waiting to see a Family Physician or Specialist

2001 Health Survey	Same day	Less than one week	1 – 2 weeks	2 weeks to one month	One month or longer
Family physician	35%	40%	13%	8%	4%
Specialist physician	10%	13%	15%	20%	43%

Source: Alberta's Health System – Some Performance Indicators, Alberta Health and Wellness, November 2001

What concerns have been raised?

In Alberta and across Canada, access to the health care system is a major concern. People worry that they will not be able to access the services they need, when they need them. When people wait longer than they think is reasonable, their frustration increases. Stories about long waits for essential services have been common in Alberta and in other provinces.

In most areas, there are not consistent ways of measuring or reporting on waiting times. This makes it difficult to compare different regions or provinces.

The Western Canadian Waiting List Project was established to address significant and long-standing problems with access to health care in Canada and to influence the way waiting lists are structured, managed and perceived. The overarching mission was to improve the fairness of the system so that Canadians' access to appropriate and effective medical services is prioritized on the basis of need and potential to benefit. Through the project, consistent tools were developed for assessing the priority of patients in five clinical specialties – cataract surgery, general surgery, hip and knee replacement, MRI, and children's mental health. The waiting list tools were based on a point-count scoring system.

In March 2001, the final report from this project was released. The report provides an overview of experience in Canada and in other countries and identifies information and policy gaps in terms of standardized ways of prioritizing patients, providing standard definitions of waiting times, and developing standards for acceptable waits.

The report recommended that consistent waiting list tools should be implemented by regional health authorities, the tools should be carefully monitored and evaluated, and the results should be effectively communicated to stakeholders. They also recommended continuing support for the Western Canada Wait List partnership and expanded work to develop new point-count systems for referrals to specialists, other procedural and diagnostic areas as well as expanded research.

There are a number of options and ideas that could be considered for reducing waiting times, in addition to the standardized assessment tools recommended by the Western Canada Wait List study. For example, in Sweden, an Internet site provides consumers with information about waiting times at each of the facilities capable of providing different treatments. People can choose an alternative site with shorter waiting times or they know how long they'll need to wait at their facility of choice.

Questions to consider

- Is waiting the price Canadians must pay for a completely publicly funded system or are there better ways of organizing the system to improve access and reduce waiting times?
- Are Alberta's waiting times acceptable?
- Aside from simply adding more money, what needs to be done to reduce waiting times to acceptable standards?
- Who should be responsible for ensuring that waiting lists are fair and based on most urgent needs?
- Who should be responsible for taking action if waiting lists increase to unacceptable lengths?
- Are there lessons to be learned from other countries about how to reduce waiting times?

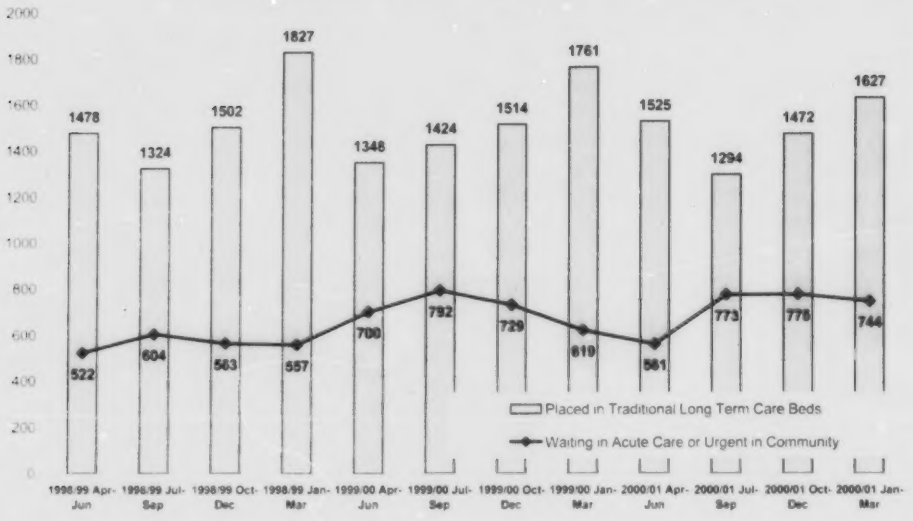
Sources of information

Alberta Health and Wellness – For more information, contact their website at www.health.gov.ab.ca.

From Chaos to Order: Making Sense of Waiting Lists in Canada. Final Report of the Western Canada Waiting List Project, March 31, 2001. Full report is available at www.wcwl.org.

The Internet Empowers Swedish Healthcare Consumers. Johan Hjertqvist, Frontier Centre for Public Policy, Winnipeg, Manitoba, May 2001

Number of Persons Placed in Long Term Care Versus Number of Persons Waiting for Long Term Care in Alberta



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Context papers:

How do Albertans use the health system and what do they think of the results?

How do Albertans use the health system and what do they think of the results?

This is one of a series of background papers prepared for the Premier's Advisory Council on Health. The background papers provide factual information on a variety of topics and pose questions for further consideration. They are intended to set a context for discussion and exploration by the Council and other interested Albertans. Copies of the background papers are available on the website for the Premier's Council at www.premierscouncil.com and also by contacting the Council's offices at 780 – 421-1848.

What's the issue?

When we look at questions related to sustaining Alberta's health system, one of the important factors is how much we use the health system. What are the current trends in utilization of Alberta's health system? How often do people use the health system and why? Are there some groups of people that use the system more than others? And related to that, what do Albertans think of the results that are achieved?

What do we know?

How do Albertans use the health system?

- On average, each Albertan received about five services from a general practitioner during 1999/00. Over 90% of those services were provided in the individual's home region.[1]
- A 1996-97 National Population Health Survey showed that:
  - 22% of Albertans said they used emergency services in the past year
  - 74% of Albertans said they visited a dentist, 67% said they had a physical exam and 59% said they had their eyes examined in the past two years.[2]
- 77% of two year old children were immunized for diphtheria, tetanus, pertussis, polio and Hib in 1998, well below the provincial target of 97%. 86% of two year olds were immunized for measles, mumps and rubella, below the provincial target of 97%.[3]
- In 1996-97, 85% of Albertans over 15 years old said they had a blood pressure check every two years. 77% of women over 18 said they had a PAP test in the last three years, significantly lower than the provincial target of 90% and down from 83% in 1985. 64% of women aged 50 – 60 said they had a mammography in the last two years, under the provincial target of 75% but significantly higher than the 1990 rate of 43%.[4]
- About 180,000 ground ambulance trips occur each year and over 6,000 Albertans are transferred by air ambulance.[5]
- The leading prescription drugs paid for by the provincial government are Losec, for ulcer treatment ($11.7 million), Pravachol, for lowering cholesterol ($4.5 million) and Norvasc, for high blood pressure ($3.5 million).[6]
- According to the Centre for Health Services Utilization, there has been a marked decrease in rates of use of hospital services. This decrease has been accompanied by increased expenditures for home care and physician services.[7]

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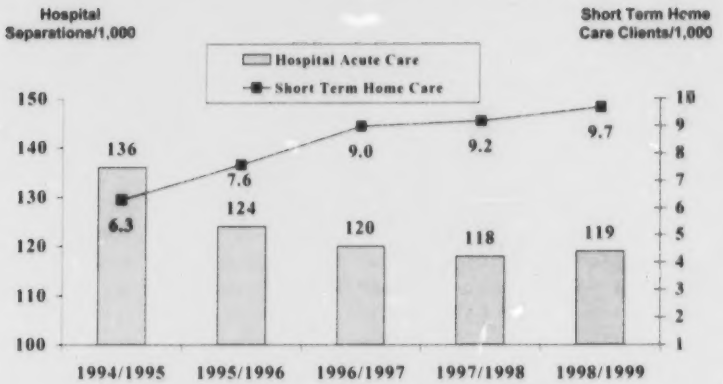
[1] *Alberta Health and Wellness Annual Report 1999-2000*
[2] *The Report on the Health of Albertans – Looking through a wider lens*. Alberta Health and Wellness, November 1999
[3] *Alberta Health and Wellness Annual Report 1999-2000*
[4] Ibid
[5] *The Report on the Health of Albertans – Looking through a wider lens*. Alberta Health and Wellness, November 1999
[6] *The Report on the Health of Albertans – Looking through a wider lens*. Alberta Health and Wellness, November 1999
[7] Ibid

Trends in Utilization of Acute Care Hospitals and Short-Term Home Care



Source: Alberta Health and Wellness Annual Report, 1999-00

- The average length of stay in hospital is 6.4 days, slightly lower than the average rate in 1993/94 (6.6 days) but higher than a low of 5.6 days in 1995-96.[8] Information from other provinces shows that, for 1998-99, the average length of stay across Canada was 7 days. The longest average length of stay was in Manitoba (9.6 days) and the shortest was in the Northwest Territories (4 days). Length of stay in Ontario, British Columbia and Alberta are about the same.[9]
- When people are hospitalized, aside from pregnancies and births of new babies, the primary reason is for heart disease. [10]
- Injuries are also a leading cause of hospitalization. In 1997, 26,851 hospitalizations were the result of injuries. Falls accounted for 37% of all hospital admissions and 137 deaths in 1997. Every day in Alberta, someone dies and 68 people are injured as a result of motor vehicle collisions. In 1998, nearly 25,000 people were injured in motor vehicle collisions, an increase of over 4% compared with 1997.[11]
- The following table shows trends in the number of people hospitalized for selected health conditions.

Hospitalization for certain health conditions

Health condition	1994-95	1995-96	1996-97	1997-98	1998-99
Alcohol/drug	2620	2377	2434	2622	2689
Asthma	4655	4270	3720	3737	3481
Depression	991	893	972	929	951
Diabetes	2874	2686	2656	2798	2946
Hypertension	1661	1403	1307	1325	1295
Neurosis	1661	1473	1441	1387	1363

Source: Alberta Health and Wellness Annual Report 1999-2000

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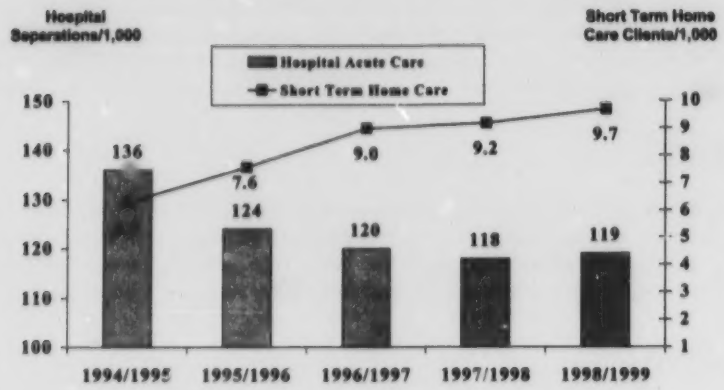

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[11] Ibid

- The following chart shows that utilization rates for certain procedures have gone down while others have remained about the same since 1994-95. It also shows large variations among regions in the utilization of some procedures.

Utilization rates for selected procedures

Surgery type	1994-95	1995-96	1996-97	1997-98	1998-99	No. of Regions above typical range
Caesarian section (per 100 births)	15.8	15.9	16.3	16.6	17.8	1
Hysterectomy (per 100,000 women 15+)	447	430	422	422	385	2
Tonsillectomy (per 100,000 under 19)	697	573	494	431	402	5
Gall Bladder (per 100,000)	241	237	238	240	240	4

Source: Alberta Health and Wellness Annual Report 1999-2000

- People aged 65 and older account for 43% of all inpatient hospital days, 71% of all home care clients, and 21% of all physician services.[12]
- The shrinking use of acute inpatient hospital services between 1991-92 and 1996-97 has been accompanied by a "greying" of the patients served. The number of patients discharged and the total number of hospital days declined more rapidly in patients less than 65 years compared with patients 65 years and older. Not only are hospital inpatients older, they are sicker (as measured by care intensity) and remain in hospital for less time.[13]
- The number of hours of home care services provided to people over 65 years old has increased from 1.8 million in 1994-95 to 2.9 million in 1998-99. Similarly, home care hours per 1000 population of people over 65 have increased from 6,933 in 1994-95 to 10,117 in 1998-99.[14]
- The number of people in long term care centres decreased between 1990 and 1996. Most people in long term care centres are over 75.[15] Long term care residents are increasingly older and sicker.[16]
- Proportionately more resources are being directed for both institutional and community care to the most elderly (85 years and older) who are predominantly women.[17]
- Between 1992-93 and 1997-98, there was a 23% increase in the amount spent on the drug plan for seniors. This increase was greater than the increase in the number of registrants (15%).[18]

What do Albertans think of the health services they receive?

- The annual survey of Albertans by Alberta Health and Wellness for 2000[19] showed that:

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[12] *The Report on the Health of Albertans – Looking through a wider lens*. Alberta Health and Wellness, November 1999
[13] *Trends in the Utilization of Health Services by the Elderly in Alberta – Overview*. The Alberta Centre for Health Services Utilization, June 1999
[14] *Alberta Health and Wellness Annual Report 1999-2000*
[15] Ibid
[16] *Trends in the Utilization of Health Services by the Elderly in Alberta – Overview*. The Alberta Centre for Health Services Utilization, June 1999
[17] Ibid
[18] Ibid

- On quality of care
  - 86% of respondents who received health services in the past year thought the quality of care was either excellent or good, a significant increase from 79% in 1999.
  - 90% rated the quality of care from their most recent visit to a physician as excellent or good.
  - 83% reported that the quality of care they had received in hospital was excellent or good, a significant increase from 74% in 1999. Ratings of quality of care received in hospital by a household member increased slightly from 77% in 1999 to 79% in 2000.
  - 67% rated the quality of health care services available in their community as either excellent or good compared with 75% in 1999.
- On access to health care services
  - 63% said that availability of health services in their community was either excellent or good compared to 74% in 1999.
  - 64% said it was either easy or very easy to get the health services they need compared to 73% in 2000.
  - In terms of which services were most difficult to access, 41% of those who said they had difficulty accessing services said access to a general practitioner (36% in 1999) was a problem, and 33% said access to a medical specialist (43% in 1999) was a problem. In comparison, about 12% said access to hospital or surgery was difficult to access, 22% said access to emergency was difficult, and 18% said access to tests and diagnostic services was difficult. Close to 70% said that long waits were the reason it was difficult to access the services they needed while 20% said it was due to a shortage of health professionals.
  - 19% said that they or a member of their household were waiting for medical treatment, consultation or tests, surgery or other services compared to 18% in 1999. Of these, 56% were waiting for consultations or tests, 26% were waiting for surgery, 15% were waiting for some other treatment, and 2% were waiting for home care or long term care placement.
  - 10% of people said they were unable to receive health services when they were needed, up from 8% in 1998.

What concerns have been raised?

At different times, concerns have been raised about possible over-use of the health system by Albertans. Some have suggested emergencies are over-used when other options should be more readily available to individuals and families. Others suggest that seniors are high users of the health system, particularly in their later years. Despite some evidence to the contrary, many Albertans worry that they will not be able to access health services when they need them.

Unfortunately, there isn't a lot of good information to confirm or refute some of these claims. A 1999 survey by the Alberta Centre for Health Services Utilization Research concluded that, although managers in Alberta's health authorities frequently use health service data, there are problems with the content, comparability, and timeliness of the information.

In May 2001, the provincial government announced the establishment of a new Health Services Utilization Commission chaired by Bonnie Laing. The purpose of the Commission is to "initiate, monitor and encourage continuous improvement in the performance of the health system by informing individuals, providers, funders and other stakeholders about the use of health services and engaging them in making positive change."

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[19] *The 2000 Survey about Health and the Health System in Alberta*. Conducted by the Population Research Laboratory, University of Alberta, September 2000

Questions to consider

- How does Albertans' use of the health system compare with other provinces and countries?
- Do Albertans use the health system appropriately? Are there ways of ensuring that we do? For example, how do we encourage people to use the health system for regular screening tests but discourage them from getting repeat tests or medical opinions?
- In order to sustain Alberta's health system, do we need to make changes in how Albertans access and use the health system?

Sources of information:

See list of footnotes
Also check the Alberta Health and Wellness website at www.health.gov for more information about the Health Utilization Commission.

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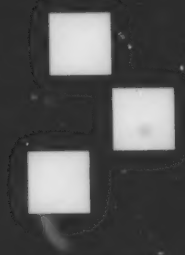

Context papers:

Do we have a shortage of health professionals?

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This is one of a series of background papers prepared for the Premier's Advisory Council on Health. The background papers provide factual information on a variety of topics and pose questions for further consideration. They are intended to set a context for discussion and exploration by the Council and other interested Albertans. Copies of the background papers are available on the website for the Premier's Council at www.premiersadvisory.com and also by contacting the Council's offices at 780 – 421-1848.

What's the issue?

Sustaining Alberta's health system requires more than money. We need to ensure that Alberta has enough doctors, nurses and other health providers to deliver the health services we need.

People hear regular reports that we're facing a looming crisis in attracting and keeping an adequate supply of doctors, nurses, technicians, and a whole range of health providers. There are continuous stories of doctors and nurses heading to the United States for better pay and better working conditions. In certain parts of the province, health authorities have serious difficulties hiring nurses and keeping doctors. Travel to job fairs, international recruitment, and various bonuses and incentives for attracting health professionals have become common tools for health authorities to try to attract the staff they need.

Alberta is not alone in facing these challenges. Other provinces and states in the U.S. are also having trouble finding and retaining health care providers. Actions in Alberta to increase salaries and establish other incentives are attracting some physicians and nurses from other provinces, but this has a negative impact on those provinces and their efforts to retain the doctors and nurses they need for their own communities.

What do we know about Alberta's supply of doctors, nurses and other health care providers? Are we still losing doctors and nurses to the U.S.? Are we facing a looming crisis, or are signs of that crisis already here today? What needs to be done to ensure that Alberta has a good supply of doctors, nurses and other health providers? And how can we ensure that health providers are used in the most effective way, given their professional skills and education?

What do we know?

The following provides some basic information on current supply and forecasts for health professionals.

A national perspective

From the 2001 annual report from the Canadian Institute of Health Information[1], we know that:

- About one in ten employed Canadians worked in health care in 1999. Many more Canadians helped to care for their friends or family members or volunteered with a health organization.
- The numbers and roles of health care professionals continue to change. So does the range of regulated professions.
- In 1999, over 228,000 RNs were employed in nursing across Canada. This is about the same as in 1998, but about 2.5% lower than five years earlier. Preliminary estimates for 2000 suggest a slight increase in the number of RNs employed.
- For the past 10 years, RNs have been more likely to miss work due to any illness or disability than any other types of shift-work occupations (e.g. police officers, firefighters, and machine operators). They also tended to be away from work for longer.

- The overall number of physicians per Canadian is about the same as at the beginning of the decade, but the mix has changed. There are fewer family doctors per person and more specialists. The percentage of female physicians is also up.
- Data from a 1997 national survey on volunteering show a substantial increase (71%) over the past decade in the number of health care organizations in which Canadians volunteer.

The following chart provides an overall comparison of the supply of certain health professionals per 100,000 people in each of the provinces and territories.

Health Professionals in Canada
Rates per 100,000 population*

	RN	LPN	Doc's	Pharm	Dent	Physio	Psych	Dent Hyg	Chiro	Optom
	1999	1998	1999	1998	1998	1998	1998	1998	1998	1998
NF	972	517	171	90	27	33	N/a	13	4	7
PE	887	452	130	79	39	36	14	24	5	12
NS	915	342	199	97	47	45	25	43	4	7
NB	1019	342	154	72	34	51	32	30	6	13
QC	788	247	212	69	53	43	85	45	12	16
ON	676	296	179	71	58	46	20	51	20	10
MB	891	227	179	77	47	43	12	47	16	7
SK	833	209	153	105	34	48	7	27	14	11
AB	740	157	167	95	53	59	50	44	18	10
BC	690	128	194	79	63	65	26	46	16	8
YK	801	214	138	65	49	N/a	N/a	39	16	10
NT/ NUN	706	164	92	66	83	N/a	56	22	N/a	N/a
CAN	746	248	186	76	54	49	34	45	16	11

Source: Canadian Institute for Health Information, May 2001
*Data are preliminary as of December 2000 and are subject to change.

Doctors

Selected information: Physicians in Canada

- "The stresses of physician shortages are apparent in Canada. Physician shortages are reported in urban as well as rural and remote areas. Many specialties are reporting shortages (e.g. anesthesia, psychiatry, radiology, obstetrics, radiation oncology) and physician morale is low. Waiting lists have grown. The single most objective sign of a physician shortage has been the significant increase in physicians recruited on 'temporary employment authorization' (from outside Canada) – 202 in 1995 compared with 790 in 1997."[2]
- The current supply of physicians will not keep pace with needs. The ratio of physicians to population is 1.85 to 1000 people (1999). By 2021, the ratio is projected to decline to 1.4 per 1000. Studies suggest the ratio should not decline below 1.9 per 1000.[3]
- To maintain a physician population ratio of 1.8 to 1.9 per 1000, Canada needs a supply of about 2500 physicians a year. The current supply is less than 2000.[4]
- Enrolments in medical schools were decreased by 10% across Canada in 1992. On top of that, Canada's medical school enrolment fell from 1536 in 1995/96 to 1498 in 1998/99. By 2000/01, the number had increased to 1692.[5]
- Even an increase of 20% in enrolments will not be sufficient to maintain our current physician to population ratios. Increasing enrolments in the year 2000 would increase physician supply beginning in

2006 and be fully in effect by 2011. Most medical schools interview 4 – 5 highly qualified students for each available position.[6]

First Time, First Year Admissions to Medical School by University of Enrolment
(Includes only Canadian Citizens and Landed Immigrants - Excludes Visa Students)

Faculty of Medicine	1995/1996	1996/1997	1997/1998	1998/1999	1999/2000	2000/2001
Memorial University (Newfoundland)	55	44	45	45	50	52
Dalhousie University (Nova Scotia)	83	83	75	83	83	82
Laval University	125	111	112	113	129	137
University of Montreal	152	155	140	132	155	158
University of Sherbrooke	88	87	89	89	102	109
McGill University	94	85	85	85	97	106
TOTAL QUEBEC	**459**	**438**	**426**	**419**	**483**	**510**
University of Ottawa	84	84	83	85	90	95
Queen's University	75	75	75	75	76	79
University of Toronto	171	172	174	176	176	181
McMaster University	99	100	100	100	100	107
University of Western Ontario	96	96	98	96	96	103
TOTAL ONTARIO	**525**	**527**	**530**	**532**	**538**	**565**
University of Manitoba	69	73	73	71	74	75
University of Saskatchewan	54	55	55	55	51	55
University of Alberta	102	102	105	105	104	126
University of Calgary	69	69	68	68	68	90
TOTAL ALBERTA	**171**	**171**	**173**	**173**	**172**	**216**
University of British Columbia	120	119	120	120	120	120
TOTAL CANADA	**1,536**	**1,513**	**1,497**	**1,498**	**1,571**	**1,692**

Source: Association of Canadian Medical Colleges

- A July/August 1999 survey done by Angus Reid showed 61% of Canadians felt there were not enough doctors practicing in Canada to meet health care needs. 45% felt there were not enough doctors in their community.[7]
- Physicians are aging, just like the rest of Canada's population. Forecasts suggest the number of physicians over the age of 55 will increase from 26% in 1999 to about 43% by 2021. By 2008, there will be more retiring physicians than medical school graduates.[8]
- Since 1995, more than 50% of new medical students are women. By 2015, women will make up 40% of the physician supply. Data shows that female physicians practice fewer hours than their male counterparts.[9]
- From 1992 to 1997, Canada had a net annual loss of about 450 physicians to the United States. More recent information shows a reduction in the number of doctors leaving Canada. There are approximately 8000 Canadian medical graduates practicing in the United States.

Doctors moving to and returning from abroad

	Moving abroad	Returning from abroad	Net Loss
1992	689	259	430
1993	635	278	357
1994	777	296	481
1995	674	256	418
1996	731	218	513
1997	659	227	432
1998	569	321	248
1999	585	343	242

Source: Canadian Institute for Health Information

What do we know about where Canada's physicians work and their worklife?

- Physicians tend to concentrate in large urban centres.
- Shortages of physicians occur not just in rural communities, but also in larger centres.
- Demands of rural practice include heavy on-call and burnout.
- Canada has maintained a better balance of family physician/general practitioners to specialists than some other countries.
- The majority of physicians are paid on a fee-for-service basis. Some are paid on a salary or contract basis for providing a range of services to a set population of patients.[10]
- In recent years, an increasing percentage of physicians are females. Information suggests that female physicians are less likely to want to work as many hours as their male counterparts.

Selected information: Physicians in Alberta

- The most recent information showed an immediate need for 333 physician FTEs (145 in general practice and 188 specialists) for 1999-2000. This is a shortfall of 7.3%.[11]
- Estimates prepared in 1999 suggested that by 2004-05, an additional 1329 physicians (610 in general practice and 719 specialists) will be needed in the province. This would amount to a 29% increase in the number of physicians in Alberta.[12]
- In 2000-01, the number of physicians in Alberta grew by 4.7%. The growth in the number of physicians in the province has outpaced population growth for the past three years and is expected to continue to do so in the coming years.
- In January 2001, announcements were made about increasing medical school enrolments to 225 – 125 at the University of Alberta and 100 at the University of Calgary. The University of Calgary has been asked to increase its undergraduate seats to 125 over the next five years. Forty additional post-graduate seats were approved as well as 40 seats for rural family medicine. This brings the total number of post-graduate residency seats in Alberta to 796.
- Retention rates of newly trained Alberta physicians are improving. Of the residents who completed training in Alberta in 1998, 68% were practicing in Alberta two years later compared to 53% in 1995.
- The number of physicians moving abroad from Alberta continues to decline. In 1999, 49 physicians moved abroad compared to 118 in 1996.
- There is a serious shortage of Aboriginal physicians – about 1 Aboriginal physician to 33,000 Aboriginal people. (Note: this refers only to Aboriginal physicians and does not include other physicians who may be serving Aboriginal people.)[13]
- Payments to physicians are one of the largest components of the provincial government's budget for health. In 2000-01, the province's projected spending on physician services was $968.3 million. The province's most recent budget projects the Medical Services Budget to increase to $1.14 billion in 2001-02 and to $1.3 billion in 2001-03.

- Most Alberta physicians are paid on a fee-for-service basis. At the end of March 2001, there were six pilot alternative payment plans in place across the province involving 68 physicians, primarily general practitioners and emergency physicians. Eleven more projects are being developed with a variety of physician groups.
- Information suggests that there may be serious shortages of some specialists in the future. For example, the average age of psychiatrists in the province is 51. An aging workforce combined with current understaffing of mental health professionals means it will be difficult to keep pace with needs for mental health programs and treatment.[14]

Number of Physicians in Alberta
1995 - 2000

	1995/96	1996/97	1997/98	1998/99	1999/00
Physicians per 1000 Albertans	1.56	1.52	1.50	1.52	1.59
Number of physicians	4,287	4,228	4,268	4,442	4,641

Source: Alberta Health and Wellness 1999/00 Annual Report

Nurses

Selected information: Nurses in Canada

- Nurses make up about two-thirds of all health professionals in Canada.
- In 2000, there were 232,412 registered nurses employed in nursing in Canada compared with 228,450 in 1999, a moderate increase of 1.7%.[15]
- RNs per population dropped from 80.3 to 75.4 per 10,000 people in 1999-00.[16]
- The average age of nurses in Canada is 43.3 years.[17]
- The number of nurses in the five youngest age groups declined and included a 24.5% decrease in those aged 25 – 29 and a 23.5% decrease in those aged 30 – 34.[18]
- Casual employment rates were at a 7 year low. In 2000, 14.9% of registered nurses were employed on a casual basis, a decrease from 18.2% in 1999 and 15.3% in 1994. Full-time employment in nursing returned to levels similar to the 1990s. In 2000, 54.8% of registered nurses were employed full-time compared to 51.1% in 1999 and 54.9% in 1994[19]
- There are fewer nurses in managerial positions. The majority of nurses work in direct care, primarily in hospitals. Canada's youngest nurses work in direct care, primarily as medical or surgical nurses.[20]
- The percentage of nurses entering nursing with a baccalaureate degree increased from 10% to almost 20% from 1994 to 2000. Across Canada, 92% of nurses graduated from a Canadian program; only 6.1% are from a foreign nursing program.[21]
- The Canadian Nursing Association reports that every province and territory is currently facing a nursing shortage. Quality, full-time nursing positions are rare while part-time and casual positions are increasing.[22]
- The Canadian Nursing Association estimates the demand for RN services will grow by 46% between 1993 and 2011. They project a shortage of 59,000 to 113,000 registered nurses by 2011.[23]
- In the mid-1990s, many RNs left Canada or left the health care profession. In 1996, the equivalent of 56% of Canadian nursing graduates emigrated to the U.S.[24]
- "All nursing associations and unions report a deteriorating quality of work life for nurses. Quality of work life is widely believed to be one of the most important factors in recruitment and retention, thus having an impact on the current and future supply of nurses."[25]
- "Head nurses and clinical nurse specialists were eliminated or severely reduced in many jurisdictions. This change reduced professional and clinical support for nurses while also transferring the responsibility for administrative duties, such as scheduling, to front-line nurses. As well, the largest loss of hospital employees during the 1990s restructuring was within the non-nursing staff, such as

ward clerks and orderlies; this resulted in many of the non-nursing duties also being reassigned to nurses."[26]

- "Nurses are the unhealthiest workers, with 8.4% absent in any week."[27]

Number of RNs Employed in Nursing per 10,000 Population by Province/Territory, Canada, 1994–2000

	1994	1995	1996	1997	1998	1999	2000
Nfld	90.7	92.2	94.4	94.7	98.3	97.3	100.2
P.E.I.	86.5	88.2	98.1	93.6	93.0	89.0	90.3
N.S.	98.8	95.3	93.6	91.8	91.0	91.6	92.3
N.B.	101.2	100.3	99.0	98.3	98.9	102.0	97.4
P.Q.	84.7	85.5	78.6	80.9	77.5	78.8	79.6
Ont	74.7	72.0	71.8	69.0	98.9	67.5	69.7
Man	89.6	90.3	92.4	92.5	89.4	89.2	87.5
Sask	83.9	83.1	83.4	82.6	82.4	83.5	83.5
AB	80.3	77.1	74.0	74.8	75.0	74.1	73.6
B.C.	73.8	72.7	72.3	72.7	69.8	68.9	68.1
Y.T.	67.0	68.9	71.0	78.9	77.5	79.0	77.9
NWT	102.2	104.1	99.6	88.6	100.0	92.3	102.7
Nun.	54.1	49.7	52.7	41.7	44.9	38.8	33.3
Canada	80.3	78.9	76.9	76.3	75.0	74.6	75.4

Source: Registered Nurses Database, Canadian Institute for Health Information

Selected information: Nurses in Alberta

- In 2000, there were 22,172 nurses in Alberta, up slightly from 21,860 in 1994.[28]
- The average age of nurses in Alberta is 43.4 years, up from 41.5 in 1994 and about the same as the Canadian average (43.3 years).[29]
- 28.5% of Alberta's nurses were over 50 years old as of March 31, 2000.
- Close to 12.6% of nurses left the health workforce in 2000.
- 38.5% of Alberta's nurses were working full time in 2000 compared with 53.3% who worked part-time and 8.2% working on a temporary basis. Close to one in three nurses worked on a casual basis.
- Alberta's regional health authorities report vacancy rates ranging from zero to 23% depending on the region and the type of nurses needed. In the spring of 1998, 62% of employers had problems recruiting and retaining community nurses while 93% said they had problems recruiting nurses for facilities in the past 12 months.[30]
- In the mid-1990s, funding for nursing education was reduced. The number of seats available to students dropped by about 35%. The number of nurses graduating dropped from a high of 898 in 1990/91 to 440 in 1998/99. Nursing programs could not accept approximately 1000 qualified applicants for the 1999-00 school year due to the limited number of spaces available; applications for admission currently exceed available seats by a ratio of 1:2.75.[31] "A modest increase in seats over the past two years will result in an increase in graduates, but programs are at capacity in terms of supply of space, clinical teaching sites, and faculty resources."[32] The province has provided funding for an increase of 575 new seats for training health professionals. That includes 247 spaces for registered nurses and 101 spaces for licensed practical nurses. A $10 million fund was also announced for continuing education for nurses.
- With recent salary settlements for nurses, the Alberta Association for Registered Nurses noted that the number of underemployed RNs/RPNs dropped from 556 in 1999 to 43 in 2000.[33]
- Good information on vacancies for RNs is not available, but regional health authorities indicate that there is a current shortage of about 1950 RNs for 2001-02. This rate is expected to continue for the next three years, which means Alberta will be short 6,000 RNs by 2003/04.
- A recent survey of nurses in Alberta[34] found the following:
  - 69% expect to be in nursing one year from now but only half expect to be in nursing in five years.

- Factors having a positive impact on both the quality of worklife and career satisfaction included: collegial relationships, making a difference in lives of patients/clients, using their unique knowledge and skills.
- Factors having a negative impact included: stress and burnout, increasing workload and complexity of work, a feeling that nursing skills and abilities are stereotyped, insufficient opportunities for advancement, rotating shifts, lack of flexibility in moving between full-time, part time and casual work, and loss of continuity in the nursing care team.

- Within three years of graduation, two out of ten graduates opt out of the profession. More than 25% of the workforce is slated for retirement in the next decade.[35]
- A new collective agreement with Alberta's nurses will make them the highest paid in the country. The agreement also provides the highest premiums for shift and weekend work, on-call and responsibility pay. Nurses will see substantial increases in education allowances, expanded benefits, payment of professional fees, and increased efforts to recruit and retain nurses. Up to 1100 full time temporary positions will be created for nurses graduating this year. New provisions will allow nurses to reduce or increase their regular hours of work. A policy supporting zero tolerance of staff abuse will be developed and implemented by employers.[36]
- Alberta provides only limited opportunities for nurse practitioners (also referred to as advanced practice nurses). Current legislation only provides for nurses to deliver extended services in under-serviced areas declared by the Minister of Health and Wellness. "Registered nurses do not want to replace physicians, but there are many places in the health care system where the use of a nurse practitioner with a holistic approach to care of the patient client would be most appropriate."[37]

Other health providers

Licensed practical nurses

- LPNs have been a part of Alberta's health care system since 1947 and have been regulated by the province since 1986.[38]
- Since 1986, the number of registered LPNs in Alberta has decreased from 8643 to 4431 in 2000.[39]
- Studies suggest that, for graduates in 2001, registered nurses and LPNs share about 72% of the same skills and competencies.[40]
- Twenty years ago, the ratio of RNs to LPNs was 1.75 to 1 in Alberta. By 2000, the ratio had shifted to 5.6 to 1. In Edmonton, the ratio was 6.7 to 1 and in Calgary it was 19.5 to 1.[41]
- There is a significant difference in the salary of an RN and an LPN. With the latest salary settlements in place, by 2002, an RN will make between $49,226 and $64,054 per year while an LPN will make from $29,359 to $35,524 per year.[42]
- The Health Professions Act was passed in 1999 and is intended to remove exclusivity of practice and increase access to an interdisciplinary coalition of health care providers. The Act has not yet been proclaimed.[43]
- More than 43% of Alberta's LPNs were over 50 years old in March 2000. Under 11% left the workforce in that year. About 35% are employed in full time positions while close to 59% work part time. Fewer LPNs work in temporary positions (6.8%) while over 28% work in casual positions.
- "Arbitrary and unfounded restrictions to the practice of LPNs and others that prevent them from practicing to the full scope of practice and in accordance with their educational preparation contribute to access to service problems. When Canadians are forced to wait for care from other providers, while appropriately trained practitioners practice below capacity, this adds unnecessary cost to the system and creates frustration and dissatisfaction with the profession."[44]

Pharmacists

- Information presented to the Premier's Advisory Council on Health suggested that pharmacists are an "untapped resource" in Alberta's health care system.
- Studies suggest that Canadian pharmacists saved the health care system $268 - $388 million in 1993. A 1996 study showed that, for every dollar invested in clinical services, on average $16.70 was saved due

to interventions by pharmacists.[45] In New Brunswick, a January 2001 report said that the work of pharmacists resulted in a 47% decrease in visits to GPs and specialist physicians.[46]

Medical Laboratory Technologists

- Medical laboratory technologists are the third largest group of health care professionals in Canada. They conduct sophisticated medical tests on blood, body fluids and tissue.
- A nation-wide shortage of general medical laboratory technologists is predicted in the next five to 15 years.
- By the year 2015, 44.4% of the medical laboratory work force will either have retired or will be eligible to retire.
- There already is a shortage of qualified medical laboratory technologists in Alberta. There are three training programs for medical laboratory technologists in the province with a total of 51 spaces available in the programs; information for November 2000 showed 47 students were enrolled in these programs.
- Attention needs to be paid to student recruitment, clinical training requirements, graduate employment, interprovincial mobility, salaries, utilization of laboratory assistants, and supply of medical laboratory technologists for rural areas.[47]

Rehabilitation practitioners

- There is an under supply of rehabilitation practitioners to provide services to acute care, in-patient rehabilitation, community health, long term care, and children's health. This applies to both rural and urban settings, but the supply problem is particularly acute in rural areas.
- Programs at the University of Alberta are being expanded to provide 10 more speech language practitioners, 6 more physical therapists, 20 more occupational therapists, and 6 more PhD grads to address the needs for more faculty members. Steps also are being taken to provide live broadcasting of continuing education, delivery of courses using the Internet, and research seminars and interdisciplinary case conferences using the Telehealth network.
- A shortage of clinical placements is a major concern.[48]

What concerns have been raised?

A number of concerns have been identified in the previous sections, but here are the highlights.

- Alberta and Canada are facing serious shortages of health professionals and providers, including physicians, nurses and other health providers. Some have suggested that provinces, especially the western provinces, should work together to address this issue.
- Education programs are being expanded, but it will take time to prepare new graduates to meet the demand.
- Increased efforts are needed to attract and retain doctors, nurses and other health providers. Suggestions include: increasing medical school enrolments and residency positions, encouraging doctors and nurses to return to Alberta, providing various incentives, providing additional grants, bursaries, and reductions in student loans, expanding permanent positions for nurses, encouraging trained health providers to return to the workforce, increase the number of front-line nursing leaders, etc.
- Alberta has made limited use of nurse practitioners and the ratio of LPNs to RNs has declined. Some suggest we need to make better use of the health providers we have and enable them to use the full range of their skills.
- Addressing the shortage of health providers may take more than simply graduating more students. Some suggest that changes are needed to improve the quality of worklife for health providers so they are more inclined to enter and stay in the health care field. Concerns also have been expressed about changing attitudes among health professionals; some are less inclined to work extended hours and are looking for options that provide a better quality of life.

- For physicians in particular, the way they are paid (fee for service primarily) may not provide appropriate incentives for physicians (general practitioners and family physicians in particular) to get more involved in comprehensive care for their patients, including steps to keep their patients healthy and well. Some people also suggest that the fee-for-service approach rewards volume of services provided and does not contribute to a healthy quality of worklife for physicians. Some physicians in Alberta are choosing to work under alternative payment plans where they are paid a set amount to provide a full range of services to a set number of people.

Questions to consider

- What actions should be taken to address current and projected shortages of health providers?
- How do we ensure that we make the best use of a mix of health providers and that "the right service is provided by the right provider"?
- Should Alberta take action to increase the use of nurse practitioners in a variety of settings or increase the number of LPNs? What needs to be done?
- What steps could be taken to improve the quality of worklife for health providers, improve their job satisfaction and their morale?
- Should the current approach for paying physicians be reconsidered?

Sources of information

Check the list of references below.

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[1] *Health Care in Canada 2001*. Canadian Institute for Health Information, May 2001
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[14] Dr. Kenneth Hashman, President, Alberta Psychiatric Association, Presentation to the Premier's Advisory Council on Health, June 22, 2001
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Context papers:

How does Alberta's health system measure up?

How does Alberta's health system measure up?

This is one of a series of background papers prepared for the Premier's Advisory Council on Health. The background papers provide factual information on a variety of topics and pose questions for further consideration. They are intended to set a context for discussion and exploration by the Council and other interested Albertans. Copies of the background papers are available on the website for the Premier's Council at www.premiersadvisory.com and also by contacting the Council's offices at 780 – 421-1848.

What's the issue?

When people think of issues in health, most often they focus on how much it costs, whether we can afford it, how long people have to wait for the treatment they need, or whether we have enough doctors and nurses. These issues are important. But we also need to look at what results we're achieving with our substantial investment in Alberta's health system.

How does the health of Albertans compare with people in other provinces and countries? What are the leading causes of illness and death in the province? Are we making progress in addressing important health issues? What health problems do we need to address on a priority basis?

What do we know?

A number of recent reports outline trends in the health of Albertans and compare our health outcomes to outcomes in other provinces and countries. The following is a snapshot of information from those reports in six key areas:

- Children's health
- Health status and determinants of health
- Deaths, chronic disease and injury
- Communicable diseases
- Mental health
- Environmental health.

Children's health

- **Infant mortality** – death in the first year of life – is recognized internationally as an indicator of population health. In 1997, the infant mortality rate in Canada was 5.5 per 1000 live births, with the lowest rate in PEI (4.4). Alberta's rate was 4.8 per 1000 births, and trends have shown a steady decline since 1986.[1] Rates of infant mortality are higher than the provincial average in two health regions: Northwestern and Crossroads. In comparison with other countries, Canada's rates are lower than the United States, but higher than countries like Sweden, Japan, Australia and France.[2]

- **Low birth weight** – is an indicator of the health status of newborns. In 1996, Canada's rate of low birth weight babies was 5.8%, with the lowest percentage in the Yukon (4.3%). In Alberta, the incidence of low birth weight has increased from 5.9% in 1990 to 6.2% in 1998. Three health regions have a higher percentage of low birth weight babies than the provincial average: Calgary, Capital, and David Thompson.[3]

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[1] *Health Trends In Alberta 2000 – Working Document*. Alberta Health and Wellness, May 2001
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[3] Ibid

- **Births to teenage moms** – are associated with low birth weights and pre-term birth. In 1996, the teenage fertility rate was 22.3 per 1000 females aged 15 – 19. Quebec had the lowest rate of teenage fertility (16.5). Alberta's rate was significantly higher at 28.5 per 1000. Since 1991, the rate of teenage pregnancies has declined. Several health regions have significantly higher rates than the provincial average, including Northwestern, Peace, Northern Lights, Keeweetinok Lakes, Mistahia, Lakeland, Crossroads, David Thompson and Chinook health regions.[4]

Health Status and Determinants of Health

- **Self-reported health** – In 2000, two out of three Albertans (66%) rated their health as very good or excellent. For 1998-99, almost 67% of Canadians rated their health as very good or excellent.[5]

- **Self-reported disability** – In 1996-97, about 19% of Albertans aged 15 and over said that their activities were limited as a result of long-term physical or mental conditions or health problems. That's slightly higher than the Canadian average of 17%.[6]

- **Life expectancy** – For 1999, life expectancy for Albertans was 81.8 years for women and 76.8 years for men.[7] That's higher than the Canadian average of 78.4 (81.2 years for women and 75.4 for men).[8] It also compares favourably with other countries like Japan, France and Sweden and is significantly higher than the United States. Within Alberta, there are some variations in life expectancy in different parts of the province. Gains in life expectancy have been greater for Edmonton and Calgary than for predominantly rural communities.[9] Provincial information is not available for life expectancy for Aboriginal people, but national information for 1986 showed that life expectancy for Aboriginal people was about nine years less than the rest of Canadians. More recent information suggests that the gap has been reduced to about 6.5 years.[10]

- **Childhood poverty** – Living in poverty increases the risk of poor health and lower life expectancy. Living in poverty is defined as the situation when 56.2 percent or more of the child's family income is being spent on shelter, food and taxes. In 1996, Alberta's rate of 20.3% was the fifth lowest rate of child poverty in the country, slightly below the Canadian average of 20.9%. Trends since 1986 show an increasing percentage of Alberta children living below the poverty line. As of June 30, 1998, 11.9% of Alberta children lived in low income families.[11]

- **Tobacco use** – Tobacco use is a serious threat to health. In 1996-97, nearly 30% of Albertans age 15 and over reported that they smoked cigarettes daily or occasionally. That's about the same as the Canadian average. Trends since 1985 show that rates have remained constant at about 30%.[12]

Deaths, chronic disease and injury

- **Leading causes of death** – In Alberta, the leading causes of death are: heart disease, cancer, stroke, injury, COPD (chronic obstructive pulmonary disease, including chronic bronchitis and emphysema), and pneumonia and influenza.

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[4] Ibid
[5] *The 2000 Survey about Health and the Health System in Alberta*. Conducted for Alberta Health and Wellness by the Population Research Laboratory, University of Alberta, September 2000
[6] *Health Trends In Alberta 2000 – Working Document*. Alberta Health and Wellness, May 2001
[7] *Alberta Health and Wellness Annual Report 1999-2000*
[8] *Health Care in Canada 2001*. Canadian Institute for Health Information, May 2001
[9] *Health Trends In Alberta 2000 – Working Document*. Alberta Health and Wellness, May 2001
[10] *Departmental Performance Report, Health Canada, 1999-2000*
[11] *Health Trends In Alberta 2000 – Working Document*. Alberta Health and Wellness, May 2001
[12] Ibid

- **Heart disease** – In 1997, Alberta's mortality rate for ischaemic heart disease (or coronary artery disease) was 125.1 per 100,000. This is lower than the national rate of 131.3 per 100,000. For the past decade, Alberta's rate of deaths from heart disease has decreased for both men and women. Seven of the 17 health regions in the province have rates that are significantly higher than the provincial average. The most recent report from the Canadian Institute of Health Information showed that people in the Lakeland, David Thompson and Calgary Health regions had the highest likelihood of surviving a heart attack of all regions in the country. Capital Health (Edmonton) was also in the top five.[13]

- **Stroke** – Alberta's 1997 mortality rate for stroke was 50.4 per 100,000 population, higher than the Canadian rate of 47.8 per 100,000. Over the past decade, the mortality rate for stroke in Alberta has gradually declined. Rates are significantly higher in three regions in the province: Mistahia, Aspen and Crossroads.[14]

- **COPD** – COPD includes emphysema and chronic bronchitis but not asthma. In Alberta, the 1997 mortality rate from COPD was 28.6 per 100,000, slightly lower than the Canadian rate of 29 per 100,000. Men are at a higher risk of dying from COPD although this is changing; the ten year rate is decreasing for men and increasing for women.[15]

- **Breast cancer** – Breast cancer is the leading cause of deaths for women in Canada. In Alberta, the female mortality rate for breast cancer was 27.1 per 100,000 in 1997, about the same as the Canadian rate of 27.3 per 100,000. The mortality rate for breast cancer has remained fairly constant over the last decade, but more recently, there has been a slight decrease in the trend.[16]

- **Prostate cancer** – Prostate cancer is the most frequently occurring tumour in men. In 1997, the mortality rate in Alberta was 31.2 per 100,000, higher than the Canadian rate of 28.5 per 100,000. The mortality rate for prostate cancer has increased slightly in Alberta over the past decade.[17]

- **Motor vehicle collisions** – The rate of deaths from due to injuries from motor vehicle collisions was 15.1 per 100,000, considerably higher than the Canadian rate of 10.2 per 100,000. Most motor vehicle collision deaths in Alberta involve teenage and young adult males. Eleven regions in the province have rates that are significantly higher than the provincial rate.[18]

- **Falls** – Alberta's rate of injury due to falls is the lowest in Canada – 5.3 per 100,000 compared with 7.8 per 100,000 for the rest of Canada. Most deaths due to falls occur with older people and are slightly more frequent for older women.[19]

- **Suicide** – In 1997, Alberta's suicide rate of 14.3 deaths per 100,000 people was the second highest in Canada and significantly higher than the Canadian rate of 12 per 100,000. Most suicide deaths involved teenage or young adult males. Suicide rates are higher than the provincial rate in six regions: Crossroads, Westview, Mistahia, Keeweetinok Lakes, Lakeland and Aspen.

- **Asthma** – Concerns have been frequently raised about rates of asthma in Alberta. Rates of mortality, though, are generally quite low. Alberta's 1997 mortality rate for asthma was 1.5 per 100,000, slightly higher than the Canadian rate of 1.3 per 100,000. Women have a slightly higher risk of dying from asthma but the rates for both men and women are decreasing.[20]

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[13] *Health Care in Canada 2001*. Canadian Institute for Health Information, May 2001
[14] *Health Trends In Alberta 2000 – Working Document*. Alberta Health and Wellness, May 2001
[15] Ibid
[16] Ibid
[17] Ibid
[18] Ibid
[19] Ibid
[20] Ibid

- **Diabetes** – Alberta's mortality rate for diabetes in 1997 was 13.5 per 100,000, significantly below the Canadian average of 17.3 per 100,000.[21]

Communicable diseases

- **HIV and AIDS** – AIDS is caused by the human immunodeficiency virus (HIV) which continues to infect increasing numbers of Canadians. In Alberta, HIV infections continue to occur at a fairly steady rate, but the number of new cases of AIDS is declining. In 1997, the rate of new AIDS cases in Alberta was 1.5 per 100,000 population, the same as the Canadian average. Among those who tested HIV-positive, the percentage of women has risen considerably since 1986 and represents 36% of all HIV cases reported in 1998. HIV positive results due to homosexual/bisexual activity accounted for only 20% of new HIV cases in 1998, down from 72% in 1991. Injection drug use accounted for the highest category of new infections in 1998. About 31% of all new HIV cases in the same year were younger people under age 30, with a number of these likely infected when they were teens.[22]

- **Tuberculosis** – Tuberculosis was once a leading cause of death in Alberta. In 1997, the mortality rate was 5.8 per 100,000 people, lower than the Canadian average of 6.5 per 100,000. [23]

- **Giardiasis and salmonellosis** – These diseases are a result of drinking contaminated water or eating contaminated food or beverages. In both cases, Alberta's incidence rates are higher than the Canadian average. The rate for giardiasis is 20 per 100,000 compared with 18.7 per 100,000 for the rest of Canada (1997). For salmonellosis, the Alberta rate was 28 per 100,000 compared with the Canadian average of 19.9 per 100,000 (1997).[24]

- **Measles, mumps and rubella** – These three diseases are highly contagious and generally involve children. Alberta's 1997 incidence rate for measles was 8.6 per 100,000, dramatically higher than the Canadian average of 1.9 per 100,000. Alberta's rates for mumps are slightly higher than the Canadian average – 1.1 per 100,000 compared with the Canadian average of 0.9 per 100,000. On the other hand, Alberta's rates for rubella were significantly lower than the Canadian average – 1.2 per 100,000 compared with the Canadian average of 13.2 per 100,000.[25]

- **Hepatitis B** – The rate of hepatitis B in Alberta has declined over the past ten years. In 1997, the incidence rate was 2.7 per 100,000, lower than the Canadian average of 5.3 per 100,000.

Mental Health

- **Mental health problems** – Mental illness affects one in five Albertans. It ranks highest in terms of costs for physicians' services - over $75 million in 1997-98. It's also an important reason why people are hospitalized; 1875 people were hospitalized for depression alone in 1997-98. The number of deaths in 1997 was 414, not including suicides.[26] In 1996, close to 7% of Albertans reported consulting with a medical professional for a mental health problem. The rates of professional consultations for mental health problems are higher than the provincial average in the Capital Health region. Rates of hospital discharges for mental illness were higher than the provincial average in all but five regions.[27]

- **Depression** – The single most prevalent mental disorder world-wide is depression. A 1996 National Population Survey found that 5.6 of Albertans over 12 scored high enough on the scale to suggest that

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[21] Ibid
[22] Ibid
[23] Ibid
[24] Ibid
[25] Ibid
[26] *The Report on the Health of Albertans – Looking through a wider lens*. Alberta Health and Wellness, November 1999
[27] *Health Trends In Alberta 2000 – Working Document*. Alberta Health and Wellness, May 2001

they were probably suffering from depression at the time of the survey. Rates of depression were significantly higher in the Capital Health region.[28]

Environmental health

- **Water and air quality** – Regular monitoring is done on the quality of water and air in the province. A large scale evaluation of Alberta's rivers done in 1996 showed reasons for concern with some of the river systems in the province. Agricultural practices such as the use of herbicides, insecticides and fungicides and intensive livestock operations are causing concerns about the quality of water and air in the province. [29]

- **Health risk assessment** – Environmental impact assessments and monitoring programs are used to identify environmental risks to health. Those studies show that:
  - In most regions, most people have access to treated drinking water, but in one region (Northwestern), under 40% of people in the region have access to treated drinking water. [30]
  - Over the past 12 years, the average number of days when Alberta's air quality was rated as fair (compared to good) was 9.7 per year, and that was due to natural weather conditions.[31]
  - Direct exposure to radiation from the sun puts people at significant risk for skin cancer. In 1996, there were 371 cases of melanoma, and 46 people died. The number is higher in southern Alberta than in the north.[32]

Impact of spending on improving health outcomes

Does spending more money on health result in better health outcomes? That's a key question in Alberta and around the world where people are searching for the best ways of improving health and containing increasing health care costs.

On an international basis, studies suggest that, among developed countries, there is no direct relationship between spending on health care services and the overall health of the population. Richer countries typically spend more on health care than poorer countries. At the same time, in poorer countries, serious under-funding of essential health services such as immunizations or basic medical treatments does have an impact on people's overall health and life expectancy. In any country, economic, social and cultural factors are powerful determinants of health, independent of how health care services are organized and delivered.[33]

International comparisons show that the United States spends considerably more on health as a percentage of its Gross Domestic Product, but health outcomes such as life expectancy, maternal mortality or infant mortality are poorer than countries that spend less, including Canada, Japan or Sweden.

From Alberta's perspective, there is little information showing that increasing expenditures on health are having an impact on improving health outcomes, although waiting times for essential services like heart surgery, cancer treatments or MRIs have been reduced.

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[28] Ibid
[29] Ibid
[30] Ibid
[31] *The Report on the Health of Albertans – Looking through a wider lens*. Alberta Health and Wellness, November 1999
[32] Ibid
[33] *International Comparisons: What we can learn from the rest of the world*. Presentation to the Premier's Advisory Council on Health, M.David Low, M.D., PhD., June 2001

Spending on Health and Selected Health Outcomes

	Total Pop (in millions) 1999	GDP/capita (US$) 1992	Health spending as % of GDP 1997	Life expectancy 1999 Male/female	Maternal mortality (per 100,000) 1990	Infant mortality (per 1,000) 1998
Canada	30.5	16,400	9.3	76.2/81.9	2.5	6
Alberta	2.9	18,745*	7.8**	76.8/81.8***		4.8****
USA	272.9	18,000	13.6	73.8/79.7	8.2	7
France	59.1	14,000	9.6	74.9/83.6	10.4	6
Australia	19.0	14,500	8.3	76.8/82.2	6.1	6
Sweden	8.9	14,000	8.5	77.1/81.9	3.2	5
Germany	82.1	-	10.5	73.7/80.1	7.3	5
Japan	126.7	15,100	7.4	77.6/84.3	8.6	4
Costa Rica	3.9	3,600	8.7	74.2/78.9	55	12
Mexico	97.6	6,300	4.7	72.8/77.1	54	16
Cuba	11.2	-	6.3	73.5/77.4	95	9
Cyprus	0.78	9,200	5.9	74.8/78.8	5	9
Greece	10.6	-	8.5	75.5/80.5	10	7
Norway	4.4	15,500	8.1	75.1/82.1	3.3	4
Netherlands	15.8	13,300	8.6	75.0/81.1	7.6	5

Source: *International Comparisons of National Income, Health Spending, Utilization, Outcomes and Patient Satisfaction*. Phuong Trang Huynh, M.P.H. and M.David Low, M.D., Ph.D., presented to the Premier's Advisory Council on Health, June 2001

*Calculated based on US exchange rate of $0.6662

**For 2000. Source: Alberta Health and Wellness

*** Source: *The Report on the Health of Albertans: Looking through a wider lens*. Alberta Health and Wellness, November 1999

**** For 1999. Source: *Health Trends in Alberta, Working Document*. Alberta Health and Wellness, May 2001

What concerns have been raised?

Albertans want a health system that rates favourably with other provinces and countries. They want to know that their substantial investment in the health system is producing positive health outcomes.

So what does all this information tell us?

- Compared to other provinces, Alberta's health outcomes are pretty good … in some cases, our outcomes are better and in other cases, they are worse.
- While international comparisons are lacking, it appears that Alberta's results are comparable, but several countries – e.g. Sweden, Japan and France – have better health outcomes based on some indicators while they spend a smaller proportion of their GDP on health.
- There are some areas where Alberta's outcomes can be improved significantly – low birth weight babies, mortality rates for motor vehicle collisions, immunizations, and incidence rates for salmonella are just three examples.
- There is no evidence to suggest that higher spending on health necessarily results in better health outcomes.

Questions to consider

- **Are Alberta's health outcomes acceptable?**
- **Are we getting good value for Alberta's investment in health?**
- **If we want to improve health for Albertans, do we need to invest more money and where?**

Sources of information

Check the list of references in the footnotes as well as the website for Alberta Health and Wellness at www.health.gov.ab.ca.

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form

Context papers:

Is the balance right?

Is the balance right?

This is one of a series of background papers prepared for the Premier's Advisory Council on Health. The background papers provide factual information on a variety of topics and pose questions for further consideration. They are intended to set a context for discussion and exploration by the Council and other interested Albertans. Copies of the background papers are available on the website for the Premier's Council at www.premiersadvisory.com and also by contacting the Council's offices at 780 – 421-1848.

What's the issue?

Alberta's health system is expected to provide a comprehensive range of services from preventing illness and injury, promoting good health and protecting public health to providing highly technical and intensive surgeries. Concerns have been expressed about whether we have the right balance in Alberta's health system. When people are critically ill or injured, we expect hospitals, doctors, nurses and other health providers to be there and provide the quality of services people need. But do we spend too much of our time and health resources on acute care in hospitals to the detriment of actions that could make people healthier in the longer term?

Often, when people think about how to judge the performance of our health system, they look at how long people wait for surgeries, not at how healthy we are and what the health system is doing to promote better health. If we're looking at ways to sustain Alberta's health system in the longer term, should more emphasis be placed on keeping people healthy, not just making them better once they're sick?

To assess those questions, it's important to look at the proportion of health funding that goes to promotion and prevention initiatives, the kinds of province-wide initiatives in place to address health issues and promote better health, and whether they are making a difference to the health of Albertans. At the same time, it's important to remember that investments in promoting good health and preventing illness and injury have long term benefits and may reduce costs at some point in the future; in the short-term, there are added costs involved in these initiatives and it takes many years to see the benefits.

What do we know?

Across Canada

The most recent report from the Canadian Institute for Health Information provides some background on promotion and prevention initiatives across Canada.[1]

- Promoting health and preventing illness are central functions of Canada's health care system. Activities range from immunization of children and others to prenatal or parenting classes and campaigns to promote healthy eating or reduce drinking and driving.
- Many provinces have introduced broad-based influenza programs to reduce illness and stress on the health system.
- Telephone triage services are spreading across the country. These services are generally available 24 hours a day, 7 days a week. They provide answers to health-related questions and advise callers on how to handle non-urgent medical conditions.
- Many Canadians regularly use prescription and over-the-counter drugs. In 1998-99, commonly taken medications included pain relievers (65% of Canadians had taken them in the past month), antibiotics (8%), remedies for colds (20%), blood pressure medications (10%), allergies (9%) and asthma (6%).
- Use of complementary and alternative therapies is increasing. Polls suggest 60 to 70% of Canadians have used some form of complementary therapy such as vitamins, mineral supplements and herbs in the past 6 months.

[1] *Health Care in Canada 2001*. Canadian Institute for Health Information, May 2001

- No information is available in the report on the proportion of provincial health funding that goes to prevention and promotion activities.

In Alberta

- Regional health authorities are responsible for providing a comprehensive range of health services to people in their region. Comparisons of how much they spend on various services show that the highest percentage – about a quarter of their spending – goes to hospital inpatient services. Close to 19% is spent on diagnostic and therapeutic services.
- In comparison, since 1997-98, regional health authorities have consistently spent about 3% of their budgets on promotion, prevention and protection initiatives. From 1998-99 to 1999-00, the percentage dropped slightly to 2.9% but the actual amount of money spent increased by 5.1%.
- Spending by regional health authorities on community and home-based services has increased slightly from 5.4% in 1997-98 to 5.7% in 1999-00.

Regional Health Authority Spending by Function

Regional Health Authority Expenses	1997-98	1998-99	1999-00	% change in actual dollars spent 1998-99 – 1999-00
Hospital inpatient	25.2	24.9	24.6	7.0
Emergency and Outpatient	7.6	8.0	8.0	8.6
Continuing care facilities	15.6	13.9	13.6	6.3
Community and home based care	5.4	5.6	5.7	10.5
Diagnostic and therapeutic	18.6	18.8	18.9	9.2
Promotion, prevention, protection	3.0	3.0	2.9	5.1
Research and education	2.1	2.1	2.3	17.5
Administration	5.6	5.9	6.2*	15.2*
Support services	14.3	15.5	15.6	8.3
Amortization	2.6	2.3	2.2	2.6
Total ($million)	2,964.1	3,222.2	3,492.3	270.4

*Increase is due to expenses for information technology and alberta wellnet
Source: Alberta Health and Wellness Annual Report 1999-2000

- Another way of looking at spending on health promotion, prevention and protection activities is to compare the proportion of the budget that goes to those activities to those that are related to acute care. Many of the functions listed above – diagnostic and therapeutic services, emergency services, administration, support services and amortization – are related to acute care services. If a portion of these costs is allocated to acute care services and promotion, prevention and protection services, the following chart shows what the proportion would be.

Proportion of health authorities' spending on facility-based acute care vs. spending on promotion, prevention and protection services

	Actual 99-00	% of total	Actual 98-99	% of total	Actual 97-98	% of total	Actual 96-97	% of total	Actual 95-96	% of total
Facility based acute care	$2130 m	91.9%	$1959 m	91.7%	$1774 m	91.3%	$1594 m	91.5%	$1528 m	92.4%
Promo., prev., prot. Services	188 m	8.1%	178 m	8.3%	169 m	8.7%	148 m	8.5%	127 m	7.6%

Diagnostic and therapeutic services and other indirect expenditures (excluding research and education, amortization of facilities) have been allocated to acute care, continuing care, community and home based services, and promotion, prevention and protection services to derive at full cost.
Source: Alberta Health and Wellness

- On a province wide basis, Alberta Health and Wellness has worked with health authorities and other stakeholders to implement a number of health promotion activities. Examples include:
  - Action for Health – provides funding to regional health authorities to plan and implement health promotion and prevention programs
  - Alberta Tobacco Reduction Plan – focuses on four strategies: tobacco-free youth, healthy and safe workplaces, clean indoor air, support for tobacco users who want to quit
  - Injury prevention – provides funding to the Alberta Centre for Injury Control to address prevention of injuries, treatment, rehabilitation and re-integration of injured individuals, and research
  - HIV – sets out a strategy clarifying the roles of various stakeholders in HIV assessment, prevention and management. Alberta Health and Wellness also supported a social marketing project to address HIV prevention for young adults and worked with Health Canada to develop a HIV prevention and management project for Aboriginal people
  - Children's initiatives – follows up on recommendations from Alberta's first Children's Forum and the Task Force on Children at Risk
  - Alberta Heart Health Initiative – funded demonstration projects in the first phase and is now in the process of investigating how to disseminate knowledge and experience across the health system
  - You're Amazing – provided information to help young parents understand than health is determined by a number of broad factors including social support, work, coping skills, income and childhood experiences.

- Provincially and within each region, medical officers of health are involved in a number of health protection and prevention activities including setting standards for food safety and inspecting restaurants, assessing air and water quality, and responding to needs for immunizations.

- A number of immunization programs have been launched including programs for meningitis, influenza and Hepatitis B.

- Alberta's immunization rates for two year old children fall short of the targets set by the province. In 1998, 77% of two year olds were immunized for diphtheria, tetanus, pertussis, polio and Hib compared with 80% in 1996. This is well below the target of 97%. In 1998, 86% of two year olds were immunized for measles, mumps and rubella, down slightly from 88% in 1997 and below the target of 97%.

What concerns have been raised?

Compared with the emphasis on acute care, people suggest that promotion, prevention and protection services are a lower priority. While many people suggest that better education and promotion programs are essential to improve the health of Albertans over the longer term, it's difficult to find the necessary resources when most available dollars are going into hospitals, health care professionals, new equipment, or more diagnostic tests.

Some people suggest that the heavy emphasis on acute care is short-sighted. Increasing costs in acute care are driving up overall costs for health services and raising concerns about whether we can sustain the system we have. At the same time, little attention is being paid to services that could actually reduce illness and injury and reduce the longer term costs to the health system.

Because the impact of promotion, prevention and protection services is longer term, there is little information available on the impact of various initiatives in improving the overall health of Albertans.

Questions to consider

- Is the balance right?
- Should more emphasis be placed on health promotion, prevention and protection services?
- What should the priorities be?

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What's the issue?

Escalating costs, new services and treatments, a growing and aging population all add up to increased spending on health care. While government spending on health was reduced in the mid-1990s, since then, spending has increased considerably. Spending on health is taking up an increasing share of the provincial budget. And some argue that we're not getting significantly better access to health care services or better health as a result.

Politicians, policy makers and pundits have all raised concerns about whether our current rate of increased spending on health is sustainable. That raises important questions like: How much is enough money to spend on health? What happens if health care takes up more and more of the province's total spending, leaving little left for other priorities like education or children's services, police, roads and highways? Is more money the answer – does it result in better health care? Are we headed for a crisis?

What do we know?

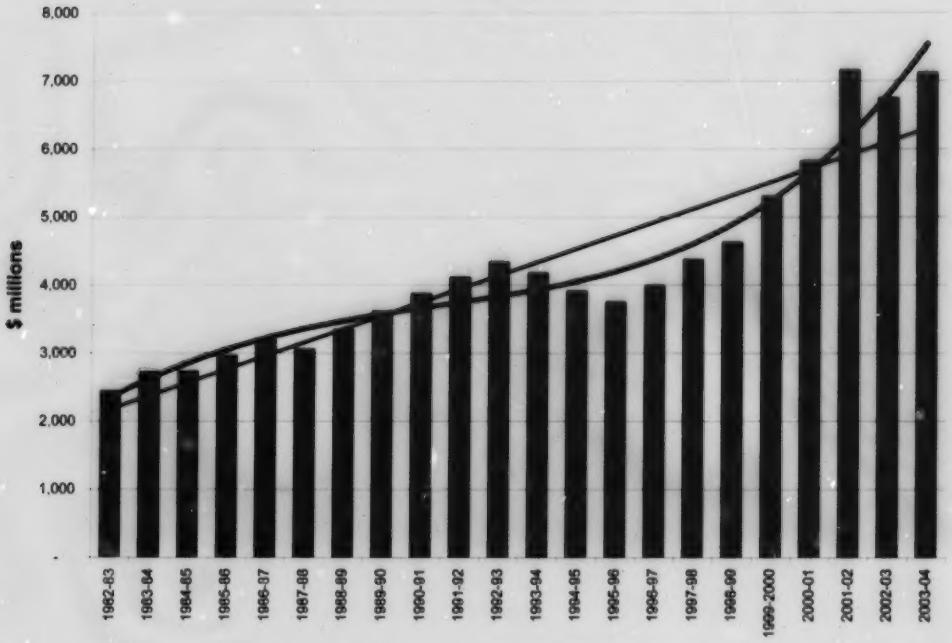
How much do we spend on health care in Alberta?

There's no doubt that Alberta spends a lot of money on health. In 2001-02, the provincial government will spend over $6.4 billion on health. If you add in capital costs, the total is over $7 billion. Provincial spending on health makes up close to a third of its total spending on programs. We spend about $20 million every day on health care. Ten years ago, Alberta spent $4.1 billion on health, about 27% of its total spending on programs.

Here are some things we know about spending on health in Alberta.

In the ten years from 1982-83 to 1992-93, spending on health increased fairly consistently. For three years, 1993-94 to 1995-96, spending on health decreased. Since then, increases in spending have been on the upswing, and recent trends show considerably higher spending on health.

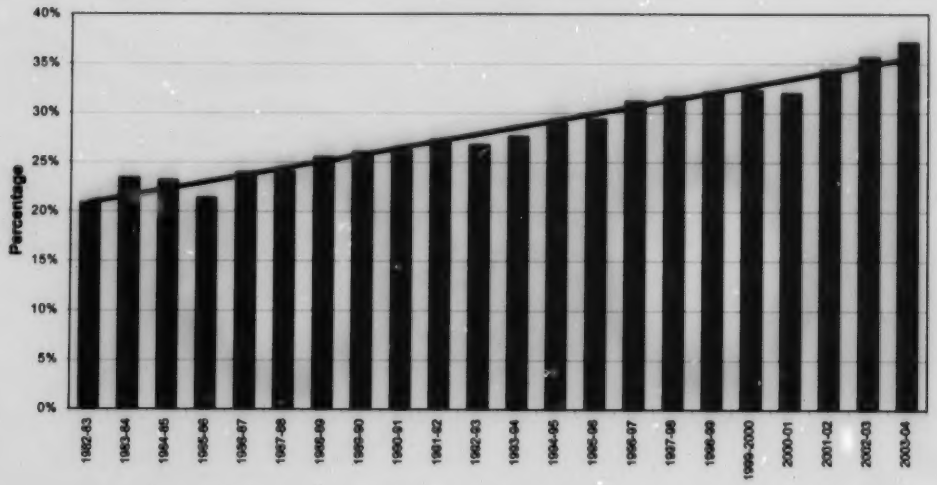
Provincial Health Expenditure - Alberta



Source: Alberta Finance, Budget 2001

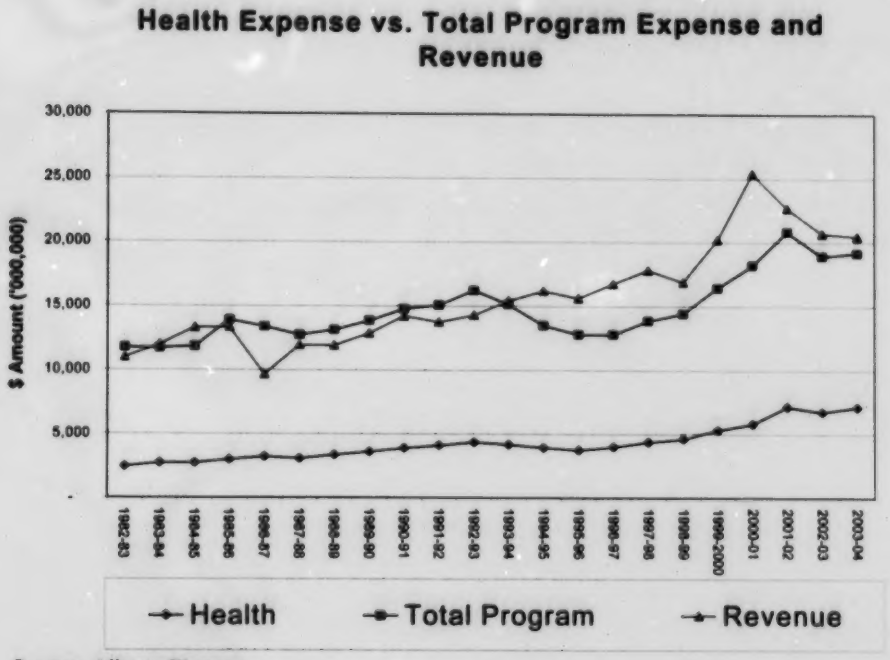
Spending on health is taking up an increasing share of the government spending pie.

Health as a percentage of Program Expense - Alberta



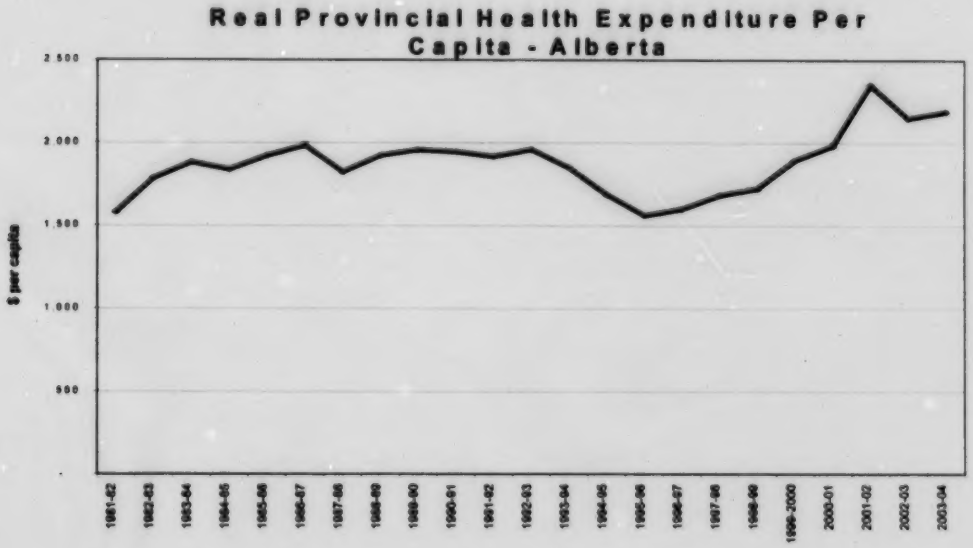
Source: Alberta Finance, Budget 2001

When government has more revenue, it spends more … on programs and especially on health.



Source: Alberta Finance

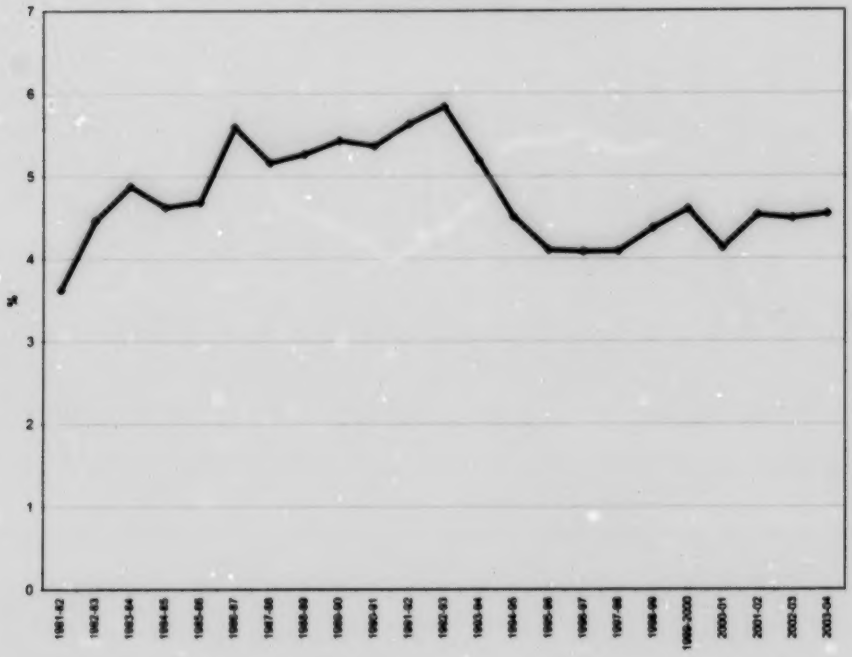
If we look at provincial spending per capita, the same pattern emerges – fairly consistent spending in the 1980s, a drop in the mid 1990s, followed by a steep increase especially in the late 1990s.



Source: Alberta Finance, September 2001

Another way to look at spending compares what we spend on health to a measure of the size of Alberta's economy – our gross domestic product (GDP). This comparison shows health spending actually dropping as a percentage of Alberta's GDP since the early 1990s. That's because Alberta's economy grew at a dramatic rate, especially in the late 1990s. The rate of growth in the economy outpaced increased spending on health, even though spending increased considerably during that time.

Provincial Health Spending as % of Nominal GDP - Alberta



Source: Alberta Finance, September 2001

How does Alberta's spending on health compare with other provinces?

Looking at Alberta's spending is one thing, but how does our spending compare with other provinces? Do we spend a lot more, a lot less or about the same?

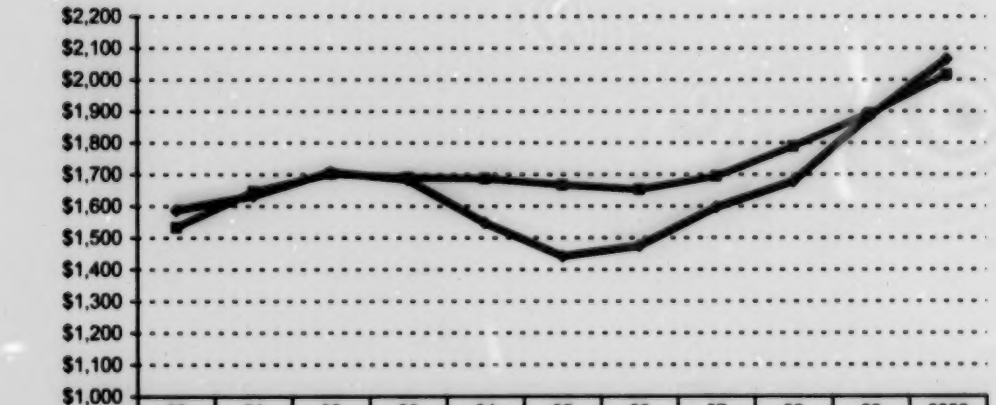
Inter-provincial comparisons of spending from 1986 to 2000 show that Alberta's spending is comparable with other provinces. While Alberta's spending dipped below the Canadian average in 1993, it climbed back above the national average in the last year. In 2000, Alberta's per capita spending on health was higher than all other provinces except Manitoba.

Total Health Expenditures
Interprovincial Comparisons

	Health Expenditure								
	% of GDP				Provincial expenditure as % of provincial program spending		Total expenditure per capita		
	Total	Public	Total	Public					
	2000	2000	1996	1996	1999	1996	2000	1996	1986
Alberta	7.8	5.3	6.6	4.5	35.4	32.1	3,299	2,343	1,830
British Columbia	10.1	7.3	9.7	7.1	32.9	32.9	3,127	2,710	1,660
Saskatchewan	9.9	7.5	8.7	6.5	38.6	35.4	3,088	2,461	1,655
Manitoba	12	9.2	10.5	7.7	39.1	35.3	3,423	2,622	1,731
Ontario	8.7	5.9	8.9	6	40.1	36.8	3,197	2,680	1,706
Quebec	9.6	7	9.4	6.8	31.2	28.8	2,814	2,341	1,571
New Brunswick	11.5	8.1	11.0	8	27.9	31.3	2,931	2,414	1,505
Nova Scotia	11.3	8.2	11.0	7.7	39.3	32.5	2,848	2,300	1,552
Prince Edward Island	12.2	8.7	11.9	8.2	31.1	29.4	2,799	2,457	1,461
Newfoundland	12.6	10.2	12.3	9.4	36.2	29.7	2,971	2,287	1,409
Canada	9.3	6.6	9.1	6.4	35.5	32.8	3,094	2,537	1,661

NOTES:
Public Expenditures: Refers to provincial government & other public sectors
Source: CIHI, National Health Expenditure Database, Albe Alberta Finance

Provincial Government Health Expenditures – Alberta and Canada
Dollars per capita – Current dollars
Unadjusted for Age/Gender Composition

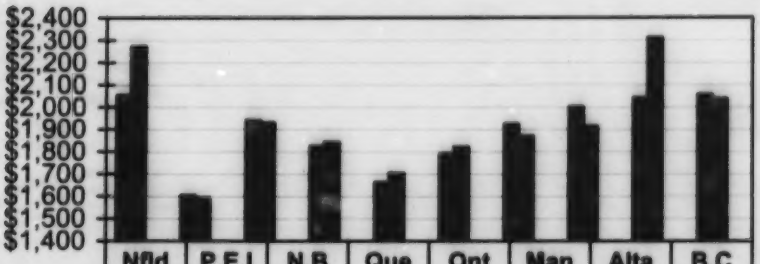


	90	91	92	93	94	95	96	97	98	99	2000
Alberta	1,587	1,632	1,707	1,684	1,547	1,442	1,474	1,596	1,679	1,886	2066
Canada	1,533	1,645	1,702	1,691	1,687	1,667	1,652	1,695	1,789	1,893	2017

Source: Alberta Health and Wellness, February 2001

Provinces differ in the age and gender mix of their populations, and this has an impact on health care costs. If spending on health in all of the provinces is adjusted to take into account the age and gender mix of the population, Alberta's spending per capita on health is higher than all other provinces and considerably higher than the provincial average.

Provincial Government Total Health Expenditures, 1999-2000
Simple and Age-Gender Adjusted Per Capita
Dollars per Capita and Ranking



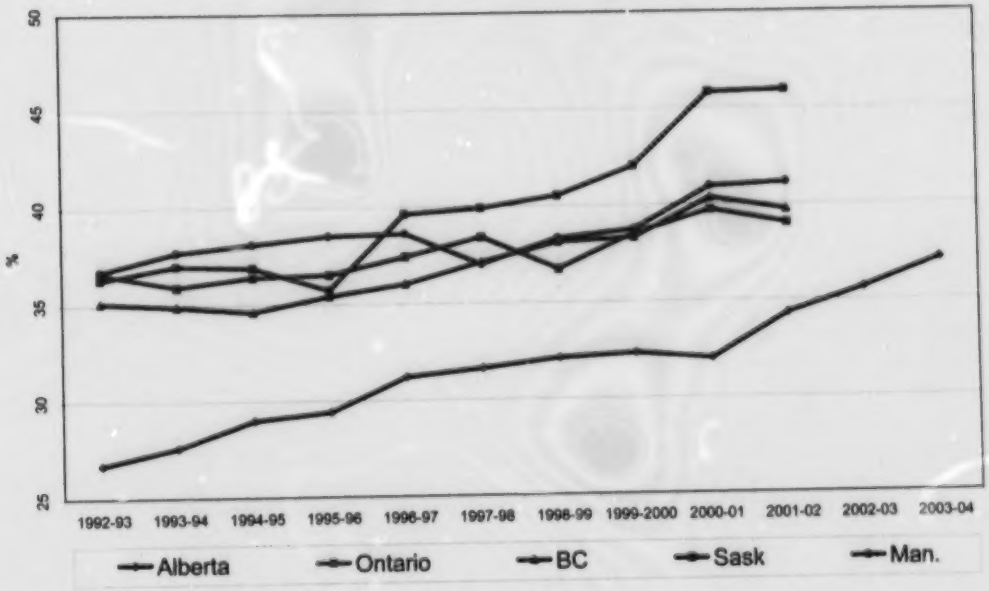
	Nfld	P.E.I	N.B	Que	Ont	Man	Alta	B.C
Unadjusted	$2,054	$1,601	$1,824	$1,661	$1,787	$1,922	$2,040	$2,053
Adjusted	$2,273	$1,588	$1,840	$1,703	$1,820	$1,870	$2,311	$2,035
Ranking Adjusted	2	10	7	9	8	6	1	3
Ranking Unadjusted	1	10	7	9	8	6	3	2

Source: Alberta Health and Wellness, February 2001

A comparison of how much other provinces spend on health compared with their GDP shows that Alberta spends considerably less as a percentage of its GDP on health (7.8%) compared with the national average of 9.3%. Provinces like Newfoundland, Prince Edward Island, Nova Scotia, New Brunswick and Manitoba spend a higher percentage on health compared with their GDP, largely because their economies are so much smaller than Alberta's. Many people suggest that comparing provinces and countries in terms of their spending on health as a percentage of GDP is misleading because it distorts comparisons between rich and poor jurisdictions. If you compare Alberta and Newfoundland, for example, Newfoundland spends about the same amount per capita as Alberta does on health, but in order to spend that much money, it takes about twice the percentage of Newfoundland's GDP compared to Alberta because Alberta's economy is so much larger.

Another way of comparing spending is to look at the proportion of a province's total spending that goes to health. Like Alberta, health is consuming an increasing share of provincial funding in all other provinces. While Alberta's percentage was consistently lower than other provinces through the early 1990's, it has increased in recent years. However, while it looks like spending in other provinces has levelled off somewhat as a percentage of total spending, spending in Alberta is on an upward trend. Ontario has the highest percentage of spending on health at well over 45%.

Health as percentage of Program Expense - Selected Provinces



Source: Alberta Finance

How much does the federal government contribute?

Health is a provincial responsibility, but the federal government provides transfer payments to each of the provinces to support health services, with the understanding that the provinces will follow the principles of the Canada Health Act.

In the late 1980s, federal support to the provinces began to decline. The Interim Report on the state of the health care system in Canada by the Standing Senate Committee on Social Affairs, Science and Technology states that, "Because of its deficit and its desire to reduce expenditures, in the late 1980s and early 1990s the federal government gradually levelled off its real contribution to health care to the provinces."[1] The report concludes that the provinces incurred continual losses in federal transfers for health care between 1986-87 and 1995-96. In the past two years, the federal government introduced a new supplement to the Canada Health and Social Transfer (the vehicle for providing funds to the provinces to support health services). With the new supplement, total federal funding to the provinces is expected to reach a high of close to $31 billion in 2000-01, slightly above the amount they provided to the provinces prior to the 1996-97 reduction.

Reductions in federal funding are seen by the provinces as a major contributing factor to the challenges they face in providing stable and adequate funding for health care. As noted in the Senate Committee's report:

> "Although the federal government introduced measures to halt cuts in CHST transfer payments and to ensure growth in transfers …, it failed, according to the provinces, to restore the cash portion to previous levels. On a number of occasions, provincial governments called on the federal government to restore the CHST cash transfer to the 1994-95 levels and to include an escalator to ensure appropriate

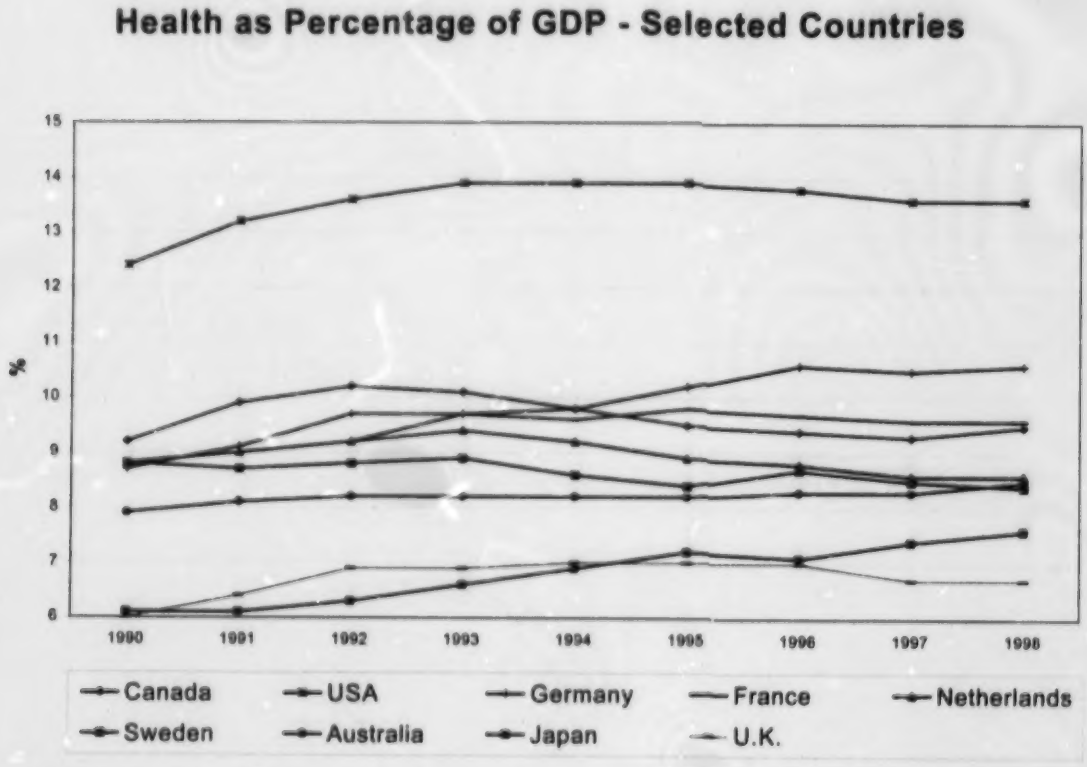
[1] *The Health of Canadians – The Federal Role: Volume One – The Story So Far*. The Standing Senate Committee on Social Affairs, Science and Technology, March 2001

growth in the CHST. In their view, this would be a major step toward stabilizing and sustaining Canada's health care system."[2]

At the same time, it may not be fair to lay all the blame at the federal government's doorstep. The federal government has significantly more debt than the provinces, pays more in debt servicing costs, and has a bigger proportionate debt load than the provinces. Just like many of the provinces, the federal government also had to take steps to reduce its spending in order to improve its financial situation.

How does Canada's spending compare with other countries?

Comparisons with other countries show that Canada spends less than the United States and Germany but more than many other countries.



Canada and Alberta are also not alone in facing projections for continuing increases in spending on health. *A Scenario for Health and Care: in the European Union of 2020*, prepared by the Nuffield Trust, looks at a number of potential scenarios for health care in the European Union. Their projections suggest that the rate of growth in spending on health care will outpace economic growth in the European Union. Spending on health care in Europe is projected to increase from 8.1% of GDP in 2000 to 12.0% in 2020. They project an increase in health costs of 3.5% per year compared with economic growth of 1.5% per year. In comparison, the Nuffield Trust report projects health care costs in the U.S. to increase to 16% of GDP by 2010.

[2] Ibid

What are the risks to sustainability?

A look at current spending on health shows that Alberta's spending:

- Has increased considerably in the past few years – by an average of 10% per year since 1996
- Is taking up an increasing percentage of total government spending
- Compares favourably with other provinces and countries.

So do we have a problem with sustainability?

The answer clearly is **yes**, for these reasons.

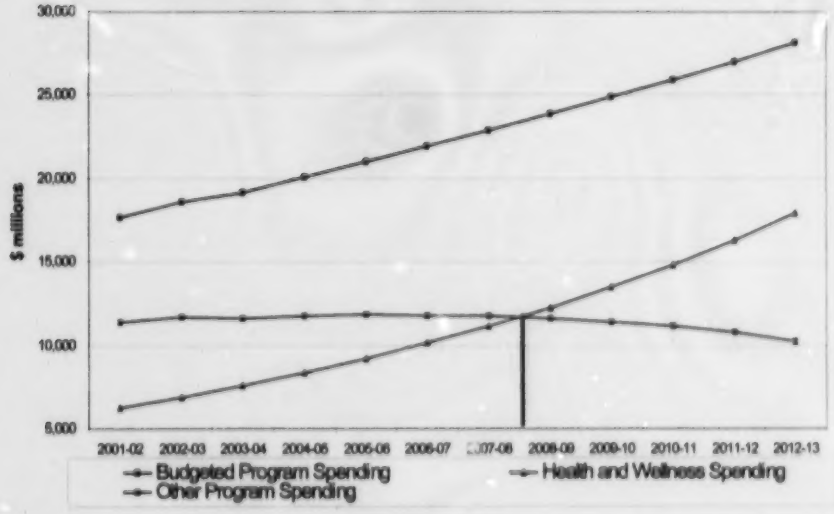
We can only afford to spend more if Alberta's economy keeps growing faster than spending.

Alberta can only sustain the current spending trends if our economy remains strong and provincial revenues stay high. Alberta has a volatile economy, heavily dependent on the price of oil and gas. If those prices level off or decline, it will be difficult to maintain current spending, let alone afford increasing costs in the future. Alberta's experience from the early 1990s points out the serious problem involved in counting on high revenues that may or may not materialize.

Health spending could soon take up half of all government programs spending.

Health spending is taking up an increasing proportion of total provincial government spending. Based on current trends, spending on health could take up half of all program spending by 2008. Are Albertans willing to spend half of all program spending on health? What impact would that have on other essential programs in education, children's services or infrastructure?

Projected Health and Non-Health Program Spending



Source: Alberta Finance
Based on: Assumes Alberta Health and Wellness spending grows by 10% per year and that overall provincial program spending tracks provincial revenue growth at 4% per year.

Costs in health are growing dramatically.

Costs in health continue to increase at a dramatic rate, and spending more money on the same or similar services does little to improve access or expand services.

Labour costs amount to about 75% of spending in health. In 2001-02, more than half of the budget increase for health went to salary increases - $390 million – primarily to support new salary agreements with physicians and nurses. The cost of those salary increases will grow to $835 million by 2003-04. Those added dollars will ensure that Alberta's doctors and nurses are better paid, but it will not provide any additional services, reduce waiting times, or address other issues in health. (These figures do not take into account an additional $200 million in funding for health authorities provided in July 2001 - $37 million of that was targeted at labour cost pressures.)

On top of that, Alberta is in a national and international race to recruit and retain health professionals, especially nurses. Traditionally, Alberta and all other provinces have lost nurses and physicians to the U.S. because of higher salaries and better working conditions. There will be added pressure in the health system to improve working conditions, expand benefits and put other incentives in place to stem the growing shortages of health providers and ensure that Alberta can compete.

New technologies, treatments and drugs are also driving up costs in health care. Every time a new MRI machine is developed, the costs escalate. The same is true for new medications and treatments. New genetic research showing the potential for gene therapy will also come with a huge price tag. The way our health system is organized means there are no market conditions that would temper the increasing costs – as long as there is only one payer (the government), there is no competition among suppliers to provide a better price and squeeze out unnecessary costs.

The fact that we have an aging population is often cited as a factor that will drive up health care costs. We know that health care costs typically increase for people in their last few years of life. But we also know that more and more people are living active and healthy lives well into their seventies and eighties. It's likely, though, that with an aging population, there will be greater expectations for home care and other initiatives to help keep people healthy and independent as long as possible.

Albertans expectations for health care are growing.

Albertans value their health system and their expectations of what it should deliver are growing. Whenever there are new treatments or technologies, we want access to them. We want and expect quick access to the health services and get frustrated when there are long waiting lists. With more and better information about health – about new treatments, new medications, and new alternatives – people are better informed about their options and they're becoming more demanding consumers of health care. Not surprisingly, there is a constant battle to balance people's growing expectations with the reality of increasing costs. Will Albertans settle for lower levels of service from their health system if costs get too high, or will they simply say, "spend more to get us what we need?"

Will spending more give us better health and better health care?

Perhaps this is the most important question.

If Albertans were to decide to just keep spending more and more on the province's health care system, would this buy us better health or better health care outcomes?

On an international basis, studies suggest that, among developed countries, there is no direct relationship between spending on health care services and the overall health of the population. Richer countries typically spend more on health care than poorer countries. At the same time, in poorer countries, serious under-funding of essential health services such as immunizations or basic medical treatments does have an

impact on people's overall health and life expectancy. In any country, economic, social and cultural factors are powerful determinants of health, independent of how health care services are organized and delivered.[3]

International comparisons show that the United States spends considerably more on health as a percentage of its Gross Domestic Product, but health outcomes such as life expectancy, maternal mortality or infant mortality are poorer than countries that spend less, including Canada, Japan or Sweden. (These measures generally assess the health of a population and don't directly address the quality or outcomes of various treatments people receive.)

From Alberta's perspective, there is little information showing that increasing expenditures on health are having an impact on improving health outcomes, although waiting times for essential services like heart surgery, cancer treatments or MRIs have been reduced.

Spending on Health and Selected Health Outcomes

	Total Pop (in millions) 1999	GDP/capita (US$) 1992	Health spending as % of GDP 1997	Life expectancy 1999 Male/female	Maternal mortality (per 100,000) 1990	Infant mortality (per 1,000) 1998
Canada	30.5	16,400	9.3	76.2/81.9	2.5	6
Alberta	2.9	18,745*	7.8**	76.8/81.8***	-	4.8****
USA	272.9	18,000	13.6	73.8/79.7	8.2	7
France	59.1	14,000	9.6	74.9/83.6	10.4	6
Australia	19.0	14,500	8.3	76.8/82.2	6.1	6
Sweden	8.9	14,000	8.5	77.1/81.9	3.2	5
Germany	82.1	-	10.5	73.7/80.1	7.3	5
Japan	126.7	15,100	7.4	77.6/84.3	8.6	4
Costa Rica	3.9	3,600	8.7	74.2/78.9	55	12
Mexico	97.6	6,300	4.7	72.8/77.1	54	16
Cuba	11.2	-	6.3	73.5/77.4	95	9
Cyprus	0.78	9,200	5.9	74.8/78.8	5	9
Greece	10.6	-	8.5	75.5/80.5	10	7
Norway	4.4	15,500	8.1	75.1/82.1	3.3	4
Netherlands	15.8	13,300	8.6	75.0/81.1	7.6	5

Source: *International Comparisons of National Income, Health Spending, Utilization, Outcomes and Patient Satisfaction*. Phuong Trang Huynh, M.P.H. and M.David Low, M.D., Ph.D., presented to the Premier's Advisory Council on Health, June 2001
*Calculated based on US exchange rate of $0.6662
**For 2000. Source: Alberta Health and Wellness
*** Source: Alberta Health and Wellness, Annual Report, 1999-2000
**** For 1999. Source: *Health Trends in Alberta, Working Document*. Alberta Health and Wellness, May 2001

What concerns have been raised?

Clearly, concerns have been raised about whether we can afford to spend increasing amounts of taxpayer dollars on Alberta's health system. But there is more to the issue of sustainability than, "Can we afford it?"

- Does the answer lie in trying to trim or contain costs? There's no way of knowing how efficient our health system is, although many suggest that there's little room for cutting costs. Improvements in

[3] *International Comparisons: What we can learn from the rest of the world*. Presentation to the Premier's Advisory Council on Health, M.David Low, M.D., PhD., June 2001

efficiency, while important, are not likely to result in any significant cost savings, but they may streamline care and improve access.

- Are we prepared to limit our expectations? One option is for Albertans, and all Canadians, to trim our expectations to fit the size of our pocketbook. But are we prepared to expect less than the best?
- Would some kind of market forces in the system help counteract increasing costs or improve outcomes? Some suggest that with the monopoly we currently have, there are no competitive forces at work to temper rising costs or improve the quality of services for the money that's spent.
- Where do we draw the line between public and private services? If there are increasing strains on the public system, are there more ways the private sector (which already accounts for 30% of total health care spending in Canada) can fill the gap, provided the basic intent of the Canada Health Act is met? Would this help reduce costs or improve outcomes? Should we be looking at ways in which people might pay at least some of the costs of medical services they consume, such as user fees?

Questions to consider

- What options should we look at to ensure that Alberta's health system is sustainable?
- If we do spend more money on health, how can we ensure that we're getting better results and better health care for the money we spend?
- Are there new sources of revenue we should be looking at to support Alberta's health care system in addition to provincial and federal tax dollars?
- Are there better financial models we should consider including tax incentives or endowments?
- How can we improve transparency and accountability in the health system so we know is we're getting good value for the money spent on health?
- Are Albertans ready to take on more responsibility for their own health?

Sources of information

Alberta Health and Wellness presentations to Premier's Advisory Council on Health

Alberta Finance

International Comparisons of National Income, Health Spending, Utilization, Outcomes and Patient Satisfaction, Phuong Trang Huynh, M.P.H. and M. David Low, M.D., Ph.D. Presentation to the Premier's Advisory Council on Health

The Health of Canadians – The Federal Role: Volume One – The Story So Far. The Standing Senate Committee on Social Affairs, Science and Technology, Interim Report on the state of the health care system in Canada, March 2001

A Scenario for Health and Care: In the European Union of 2020. Graham Lister, The Nuffield Trust For Research and Policy Studies in Health Services. December 1999

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Context papers:

What factors are driving costs in health?

What factors drive costs in health care?

This is one of a series of background papers prepared for the Premier's Advisory Council on Health. The background papers provide factual information on a variety of topics and pose questions for further consideration. They are intended to set a context for discussion and exploration by the Council and other interested Albertans. Copies of the background papers are available on the website for the Premier's Council at www.premiersadvisory.com and also by contacting the Council's offices at 780 – 421-1848.

What's the issue?

Health care costs are increasing not only here in Alberta, but across Canada and around the world. In Alberta, spending by the provincial government on health care has increased by an average of 10% a year since 1996. Across Canada, total spending has increased from $11 billion in 1977-78 to $56 billion in 1999/2000. Many have suggested that, unless something is done, Canada's health system is not sustainable.

What factors are driving those increasing costs and is there anything we can do to control them?

What do we know?

In August 2000, Canada's provincial and territorial Ministers of Health released a report called *Understanding Canada's Health Care Costs*. The report provided historical background on changes in health care funding by provincial and federal governments and identified cost drivers, cost accelerators and the cost of reform in Canada's health system.

The following are some highlights taken from that report.

- Three issues are at play in health care reform: (1) sustainability of the current publicly funded health care system, (2) improving and assuring Canadians' access to quality health care service, (3) how best to improve the health status of Canadians.
- Cost drivers such as Canada's growing and aging population and inflation are projected to increase provincial/territorial health expenditures from $56 billion to $85 billion in 10 years.
- This is almost certainly an underestimate, as it does not take into account cost accelerators such as emerging and new technologies, the increased incidence of chronic and new diseases, and the significant costs of system renewal. This could bring total provincial/territorial health spending to over $100 billion within 10 years.
- Even with modest changes in the pattern of service delivery, basic factors (population growth, aging, inflation, rising costs for current programs) are projected to increase health expenditures by approximately 5% per year over the next 27 years, for a total increase of almost 250% by 2026. (Note: State Medicaid expenditures in the US are projected to increase at a rate between 4.6% and 7% annually for the next 5-10 years, with most observers expecting the higher rate.)
- From 1996-1999, increased spending on health care has averaged 4.2% annually, the same as growth in the economy. Preliminary indications are that the provincial/territorial spending increase for 2000/01 is significantly higher than this.
- Since the beginning of block funding in 1977, the growth of health care spending has averaged 0.8% higher than the growth of the economy.

Factors Predicted to Increase Health Care Costs

- **Basic Cost Drivers** – population growth, aging, inflation (including wage rate increases), rising costs for current programs, diffusion of safer, less intrusive technologies that cost more than existing interventions.

- **Accelerators** – emerging and new technologies such as major joint surgery, neonatal and fetal technologies, dialysis, organ transplantation, genetic testing and therapy, pharmacogenomics and genetically specific drug design, and increased incidence of chronic and new diseases such as heart disease, diabetes, tuberculosis, Hepatitis C, HIV/AIDS; new pharmaceuticals, declining productivity gains, and rising consumer expectations.

- **System Change & Reform** – structural changes, method of service delivery, scope of programs and services, effective roles of providers, information systems, research and new management structures to ensure continuous innovation and quality improvement/assurance.

Basic Cost Drivers

- Population increases have an impact on spending on health. But in the next ten years, spending on health care is projected to grow by 58% while Canada's population is projected to grow by less than eight percent.

- On a per capita basis, the average spending on health across the country is about $1759 per person. By 2026/27, the costs could rise to over $5000 per capita.

Health Costs, Canada 1999/00 to 2026/27

Year	$ per Capita	Increase over five years ($)
1999/00	1759	
2004/05	2121	362
2009/10	2571	450
2014/15	3135	564
2019/20	3831	696
2024/25	4726	895
2026/27	5143	-

Source: Understanding Canada's Health Care Costs, Final Report, p. 32

- Age has an impact on health care costs. Currently, people over 65 make up about 12.5% of the population and consume 45% of health care expenditures. People aged 45 – 64 consumes an additional 21% of health care resources. By 2026/27, when seniors make up about 21% of the population, about 60% of health spending could be devoted to caring for people in this age group.

Share of operating health spending by age group, Canada (per cent)

	1999/00	2004/05	2009/10	2014/15	2019/20	2024/25	2026/27
0 – 14	7.4	6.5	5.8	5.3	5.0	4.6	4.5
15 – 44	26.4	24.4	22.3	20.6	18.9	17.3	16.6
45 – 64	20.9	22.8	24.2	23.5	21.9	19.8	19.0
65+	45.3	46.3	47.7	50.6	54.2	58.3	59.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Understanding Canada's Health Care Costs, Final Report. P. 34

- Aside from population growth and aging, the cost of programs and services in health continues to increase.
    - Hospitals are the largest single cost in Canada's health care system. By 2026/27, spending on hospitals could rise to $86 million, about three and a half times the spending levels in 1999/00.
    - Physicians' services are the second largest provincial/territorial health spending item. By 2026/27, spending on physicians could amount to $36 billion, about triple the level in 1999/00.
    - Drug expenditures are expected to increase significantly. They could rise from $4 billion today to over $15 billion by 2026/27, almost a fourfold increase.

Cost Accelerators

Looking at basic cost drivers, we can project increases in health costs in the future, but those basic cost drivers alone likely result in an under-estimate of what future costs could be. In fact, utilization of the health system is expected to increase significantly in the future because …

- Demand for care may exceed current supply, such that current utilization can't be considered to be fully reflective of demand.

- New clinical research is identifying populations that can benefit from health technologies that they haven't been receiving.

- Emerging and new technologies and treatments will allow us to treat conditions that were previously untreatable.

- The scope of current programs may be changed to meet changing demands and expectations.

Factors that could accelerate increases in health care costs include the following:

- Age composition of population and implications for long-term care - - The group 85+ uses dramatically more residential long-term care than either the 65-74 or 75-84 groups. Over the next decade, the number of people over age 85 will grow by 61%, as compared to 21% for the population age 65+.

- Emerging and new technologies – The dissemination and rate of use of emerging, very high cost, publicly funded technologies and treatments are likely to increase dramatically. Reasons for the increase include demonstrated efficacy and more acceptance in the field, greater availability of technologies, expanded provider capability, and increasing consumer demand. Examples include:

    - Cardiac care and the increased use of cardiac revascularization services
    - Stroke therapies and the decline in stroke mortality rates and continuing increase in the number of dependent stroke survivors
    - Major joint surgery – The degree of under-use is three times as great for women as it is for men. New technologies, earlier interventions and more applications to women will significantly increase the cost of this intervention over that predicted from current rates of use and cost.
    - Organ transplantation – As new programs raise donor awareness, growth in the number of donors will increase the number of transplants.
    - Dialysis – The incidence and prevalence of end stage renal disease (ESRD) have increased greatly in Canada over the last two decades, increasing demand and need for dialysis.

- MRI – Canada currently has one of the lowest dissemination of MRI of any country. Increased demand will lead to increased dissemination and use of MRI technology in the near future.
- PET – Recent advances in the technology have reduced the cost of purchasing the equipment. As the usefulness of the technology in diagnosis and treatment is demonstrated, demand for access will likely increase.
- Genetic testing & therapy – There will be pressure to expand the number of organizations that can provide testing and treatments. Gene therapy will also place pressure on drug costs as pharmaceutical companies race ahead with the development of new drugs, DNA-array chips, etc. to diagnose and treat many diseases including cancers, diabetes etc.
- Viral vector and other gene therapy technologies will be both extremely expensive and very attractive for those suffering from heretofore poorly treated disorders.
- Stem cell and related therapies for spinal cord, brain and other tissue and organ repair/re-growth will soon become available and will also be extremely expensive.
- Nanorobotics, liposome technology and other exotic delivery systems will improve treatments but raise costs significantly

- Increasing use of more effective pharmaceuticals – aging of population (average age of 54-57), development of new replacement drug therapies, and shift from hospital to community care, increase in introduction of new drugs; direct-to-consumer drug advertising stimulates consumer demand and has the potential to increase the costs of care beyond just the cost of the drugs (i.e. increased physician visits)

- New diseases – HIV/AIDS, Hepatitis C, traumatic brain injury, Tuberculosis, Diabetes and its complications

- Information systems, management and communications – The Health Services Restructuring Commission in Ontario estimated that an increased spending of $700 million on information systems would be required. Nationally, this could extrapolate to well over $1 billion.

- Changing expectations – use of the Internet, increased use of home care, increased doctor visits, additional diagnostic testing, demand for shorter waiting times, demand for advanced technology and surgical procedures, demand for alternate services (short-term care, rehab, elder care, palliative care, respite care), and the need for clinicians to stay up to date could all drive up costs.

- Higher rates of illness, chronic conditions, and premature death occur in certain regions of Canada and in Aboriginal communities.

- Cost pressures faced by jurisdictions related to population density and geography vary across the country. For example, in Nunavut, transportation costs alone account for 20% of health and social spending.

- Rural and remote communities have difficulty recruiting and retaining service providers. Those challenges, combined with the long distance involved mean that rural and remote service delivery costs per patient are increasing at a rate faster than the health system in general.

- Declining productivity gains – Productivity levels related to increased use of ambulatory surgery, reduced length of stay in hospital, increased hours per unit of workload, decreased home-care visits per episode, and reduced overhead costs, will stabilize.

- Shortage of trained staff (particularly nurses, physicians, and technologists) will drive up costs of recruiting and retaining qualified staff.

- There will be a continued acceleration in the costs of equipment due to introduction of new technologies, increased rate of technological change (and equipment obsolescence and replacement), and broader dissemination of existing technologies.

- We can expect an acceleration in the capital costs associated with the health system due to replacement of Post-War facilities, replacement of inner-suburbs facilities from the 60s, new facilities for new suburbs, restructuring/regionalization, and consolidation, and the changing characteristics of long-term care.

System Change and Reform

Health systems in every province and territory in Canada have gone through considerable change in the past five years. As the report from the Health Ministers states, "These reforms have been undertaken to modernize the health system to better serve Canadians." Changes include improvements in delivery and management of hospital care, improving access to physicians' services and primary health care, rapid expansion of home care and other community services, investments in long term care, and improving access to new technologies. The conclusion the Ministers draw from these reforms is that:

- The purpose of health reform is not to reduce spending levels. It is to improve access, quality and cost effectiveness. It may also help moderate future growth curves.
- Reforms will require significant investments.
- Provinces and territories will continue to identify cost efficiencies, however, it will be extremely difficult to replicate the efficiencies gained in the 1990s in the near term. Cost pressures will continue at a rapid rate.

Looking ahead, structural changes can be anticipated in the method of service delivery, scope of programs and services, effective roles of providers, information systems and new management and research structures to ensure continuous innovation and quality improvement. Examples of how health reforms can increase costs include:

- Proposed expansion of Pharmacare into a fully funded comprehensive national program

- The expansion of home care to meet demand and to provide the community services to support the reforms underway. Emerging telemedicine technologies soon could also drive up the demand for in-home health services.

- Primary care reform will develop and implement a costly comprehensive and integrated information technology system.

- Proper integration of mental health services into the main body of health services.

- Comprehensive technology assessment and research related to improving quality and reduction of medical error and regional variations in patterns of practice.

What concerns have been raised?

A day rarely goes by without a story in the media about new technology, new medical advances, the need for more health care providers, or new programs that are needed – all at considerable costs.

Health Ministers across the country have said the system is not sustainable without major changes. While Canadians and Albertans want access to the latest medical advances and do not want long waiting times for major treatments, the costs are mounting and there do not appear to be effective mechanisms in place to control costs.

Is the only answer to keep spending more of taxpayers dollars on health care services? Are there ways of containing costs?

Questions to consider

- Are Albertans prepared to spend more to get access to the health services they want and expect?
- What options should we consider aside from simply increasing provincial and federal spending on health?
- What can or should be done to manage and contain rising costs?

Sources of information:

Understanding Canada's Health Care Costs, Final Report. Provincial and Federal Ministers of Health, August 2000. Available at http://www.scisc.gc.ca/cinfo00/850080012_e.html.

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The Opportunity for People and Communities to Improve Their Own Health

How to enable people and communities to take more responsibility for their own health.

Position Paper prepared by Larry Bryan

The following paper attempts to provide ways to enable people to desire, and to have the capability to take more control of their health. The paper begins with **The Opportunity** (pages 2 to 17), a background section providing information on the significance and prevalence of most major illnesses and risk factors for those illnesses, as well as scientific studies showing steps that could be taken to diminish the impact of these illnesses. Including all diseases is impossible, but enough are covered, in my view, to demonstrate the enormity of the opportunity, which seems to me, to be the most essential feature of our task.

Although **The Opportunity** section is directed to showing how personal habits and behaviour (using Canadian prevalence data) can influence health, many of the opportunities may also respond to continuing efforts to enhance population health through reduction of economic, social, and educational gradients in our society. This topic, the **Determinants of Health**, is briefly summarized (pages 18 to 19) primarily to bring out economic, social and educational gradients detected in the National Population Health Surveys (NPHS) carried out by Statistics Canada. No attempt has been made to examine the arguments for and against the concept of **Determinants of Health** as this has been extensively argued in the past and has been accepted in principle by most governments of Canada. Thus its treatment is rather brief.

A **Proposal for Action** is presented following the above sections (pages 20 to 26). Herein a summary of the role of economic, educational, social, and health gradients is restated and recommendations made for additional steps - primarily in the field of childhood education. Most of the actions that could be proposed pertinent to the Determinants of Health are based on government policies in areas other than Health. It is not practical for our Council to make recommendations on such far reaching areas of government except to provide ongoing support, and in critical areas like early childhood development and education, to make additional strong recommendations.

The second part of the **Proposal for Action** is directed to recommendations to enhance individual behaviour. The recommendations include better and/or different incentives for individuals and providers, development of an "informationist" capability, a dedicated mandatory health theme in schools, a concerted program to diminish tobacco use, a new food guide and industry collaboration, community initiatives, programs dedicated to specific age groups and new health providers. This list is already substantial and will need prioritization. Others could be added but I have chosen to provide this list to open the discussion.

Finally an **Appendix** outlining the organization of the Ministry of Children Services in Alberta, and a survey done in 1998 on early childhood intervention across Canada by the Government of the Northwest Territories' Joint Working Group (JWG) on Early Childhood Intervention is included. This information is provided because of the critical role that early childhood and education of youth plays in the ultimate health of individuals.

The Opportunity

The following is a presentation of the incidence of major illness risk factors and diseases in Canada combined with selected major international health studies to provide the basis to show the huge opportunity for health improvement in this country. Reasonable estimates of the frequency and effect of risk factors and illness have been provided by death rates and by the periodic National Population Health Surveys (NPHS) of 1994/95, 1996/97 and 1998/99 by Statistics Canada (Health Reports, Volume 11, Number 3 March 2000, and Health Reports Volume 12, Number 3, April 2001).

Enhanced length of life, reduced disability and lowered health costs.

Low risk-factor profiles with respect to serum cholesterol, blood pressure and not smoking have been shown to be associated with an estimated longer life expectancy of 5.8 to 9.5 years in large scale US studies. Available data indicated the low risk favorable status applied to whites and African Americans and for those of higher and lower socioeconomic status. The percentage of the populations followed who were at low risk did not exceed 10% in each of the groups examined. (Stamler, J. et al. Low risk-factor profiles and long-term cardiovascular and noncardiovascular mortality and life expectancy. *JAMA* 1999;282:2012-2018).

Low risk behaviour, defined by non smoking, body mass index and exercise patterns, leads to longer life. As well disability is postponed by more than 5 years and compressed into fewer years at the end of life. This study followed 1741 people for health behaviour and disability from 1962 to 1994. (Vita AJ, Terry RB, Hubert HB, Fries JF. Aging, health risks and cumulative disability. N Eng J Med 1998;338:1035-1041). Ill health in older people can undergo significant improvement - Canadian survey data of older Canadians showed about 1/2 of those reporting fair or poor health in 1994/95 reported an improvement in 1998/99. (How Healthy Are Canadians? Health Reports, 2000 Volume 11, Number 3).

One of the best studies on health care costs was reported by Daviglus et al. A low risk group was defined by three risk factors - serum cholesterol <5.2 mmol/L, blood pressure ≤120/80 and not smoking in people who had no ECG abnormalities, and did not have a history of diabetes or myocardial infarction at the time of enrollment. Follow up was for an average of 23 years and health care costs were tracked by utilization of US Medicare. For men the low risk group had total charges less than two-thirds (~ 54%) of those not at low risk, and for women the costs were less than one-half (~40%) of those not at low risk. Charges were also significantly less for both men and women who had one or two of the risk factors compared to those having all three of the risk factors. (Daviglus ML, Liu K, et al. Benefit of a favorable cardiovascular risk-factor profile in middle-age with respect to medicare costs. N Eng J Med 1998;339:1122-1129.)

Cardiovascular disease

In 1996 cardiovascular diseases accounted for 37.3 % of all deaths in Canada. Death rates per 100,000 population from ischemic heart disease have been declining since about 1970 and those from strokes since about 1960. Canada's age-standardized mortality rate for cardiovascular disease, in the mid-1990s, is relatively low compared to many countries but still sits well above countries like France and Japan. Circulatory diagnoses accounted for the second largest rate of hospital separations in Canada in 1995-6 being just behind that for pregnancy and childbirth. The rate was a little over twice the rate for neoplasms.

Ten % of all Canadians over 12 years suffer from hypertension (blood pressure >140/90), climbing to 22% for age 55 to 64, 31% age 65 to 74 and 34% age 75 or over. This represents 2.5 million Canadians. There is an association with education, in that hypertension is most common in those with less than high school (12%), and least in those with university (8%) education. Ten % of Canadians take medications for blood pressure. Elevated blood pressure is a significant risk factor for heart disease and stroke and is associated with reduced longevity.

A sentinel study on prevention of coronary heart disease (ischemic heart disease) was published in 2000 using the Nurses Health Study data. (Stampfer MJ, Hu FB, Manson JE, Rimm EB and Willett WC. Primary prevention of coronary heart disease in women through diet and lifestyle. N Eng J Med 2000;343:16-22) It showed, based on study of 84,129 women since 1980, that **82%** of coronary events (heart attacks, deaths) could be attributed to a lack of adherence to a low risk behaviour pattern. The optimal pattern involved:

* dietary guidelines (based on intake of trans fats [<1.56% of energy], cereal fibre [> 4.2 g per day], marine n-3 fatty acids [>0.1 % of energy], folate [>525 µg/day], glycemic load [<723 units /day], ratio of polyunsaturated to saturated fat [>0.43])
* smoking – never smoked or stopped smoking
* exercise – an average of at least 1/2 hr. per day of vigorous exercise such as brisk walking
* body weight – BMI < 25
* modest alcohol intake – an average of at least 5 g alcohol per day (one typical glass of wine has 11 g of alcohol).

Various other behaviour combinations reduced the risk of heart disease but less than the optimal low risk pattern. **Only 3.1%** of the group fell into this pattern even though it requires very modest commitment unless one is a smoker. As comprehensive a study has not been done on men but most studies that include men are consistent with these findings.

A sentinel set of clinical trails have been performed to examine dietary effects on blood pressure. The Dietary Approaches to Stop Hypertension (DASH) trial demonstrated that a diet that emphasizes fruits, vegetables, and low-fat dairy products, that includes whole grains, poultry, fish, and nuts, that contains only small amounts of red meat, sweets, and sugar-containing beverages, and that contains decreased amounts of total and saturated fat and cholesterol, lowers blood pressure substantially both in people with hypertension and those without hypertension, as compared with a typical diet in the United States. A second trial showed that reduction of sodium intake either to levels below the current average consumption or below the current recommendation of 100 mmol per day, and the DASH diet, together lower blood pressure substantially, with greater effects in combination than singly. Long-term health benefits will depend not only on the ability of people to make long-lasting dietary changes but on the **increased availability of lower-sodium foods**. (Sacks FM, et al. Effects on blood Pressure of reduced dietary sodium and the dietary approaches to stop hypertension (DASH) diet. N Eng J Med 2001;344:3-10).

In the US, and probably similarly in Canada, approximately 50 percent of the adult population and 80 percent of those 50 years of age or older have a blood pressure of at least 120/80 mm Hg or higher. The value of 120/80 is of significance because it is widely considered optimal and is associated with increased longevity. The DASH diet to reduce blood pressure, is fully consistent with the dietary principles provided above to reduce heart disease and is broad with wide choice and opportunity for variety.

It is extremely important to recognize that the disease atherosclerosis which underlies almost all heart disease and stroke begins in early life. Several studies have documented its extensive presence in teenagers in the US. Thus prevention of the devastation of these disease must start early to be optimally effective.

Diabetes and other Chronic Diseases – the relationship to Body Mass -

A body mass index (BMI) of ≥ 25 has been repeatedly shown to increase health risks. The elevated risk is particularly **profound for diabetes** (Figure 1)but has clear impact for the risk of gallstones, hypertension, heart disease, and colon cancer (Figure 2). Recent studies confirm the elevated risk at BMI 25 but also demonstrate some increase in risk at lower BMI. It appears risk is continuous from about BMI ≥22 but accelerates at BMI 25. (Field AE, Coakley EH, Must A, Spadano JL, Laird N, Dietz Wh, Rimm E, Colditz GA. Impact of Overweight on the Risk of Developing Common Chronic Diseases During a 10-Year Period. Arch Intern Med 2001;161, 1581-1586). The effect of high body mass seems lessened for individuals older than 65 yr. but even in the elderly a BMI of ≥ 27 is a definite health risk.

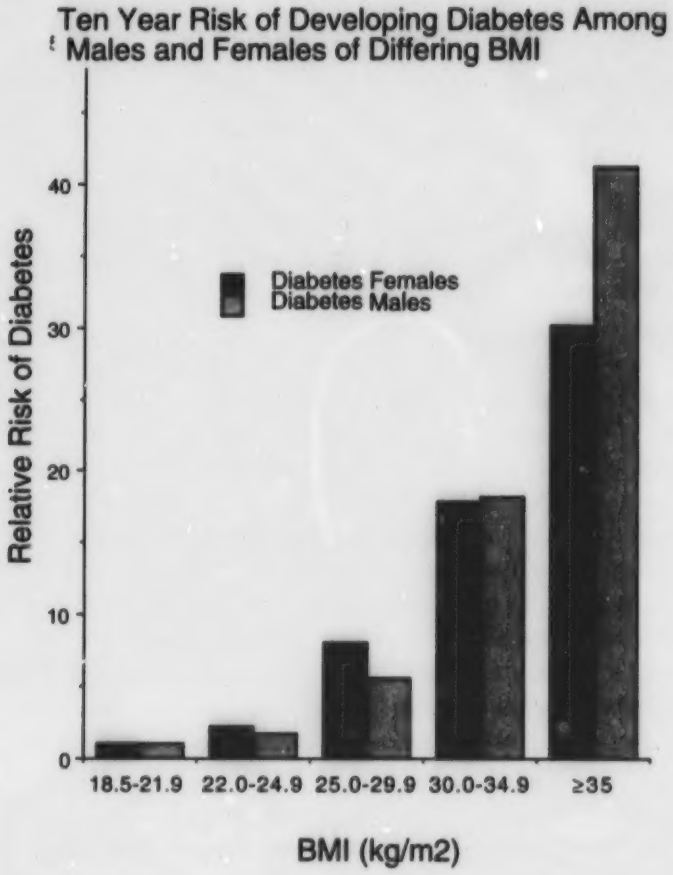


Figure 1

Figures 1 and 2 are adapted from Field AE, Coakley EH, Must A, Spadano JL, Laird N, Dietz WH, Rimm E, Colditz GA. Impact of Overweight on the Risk of Developing Common Chronic Diseases During a 10-Year Period. Arch Intern Med 2001;161, 1581-1586

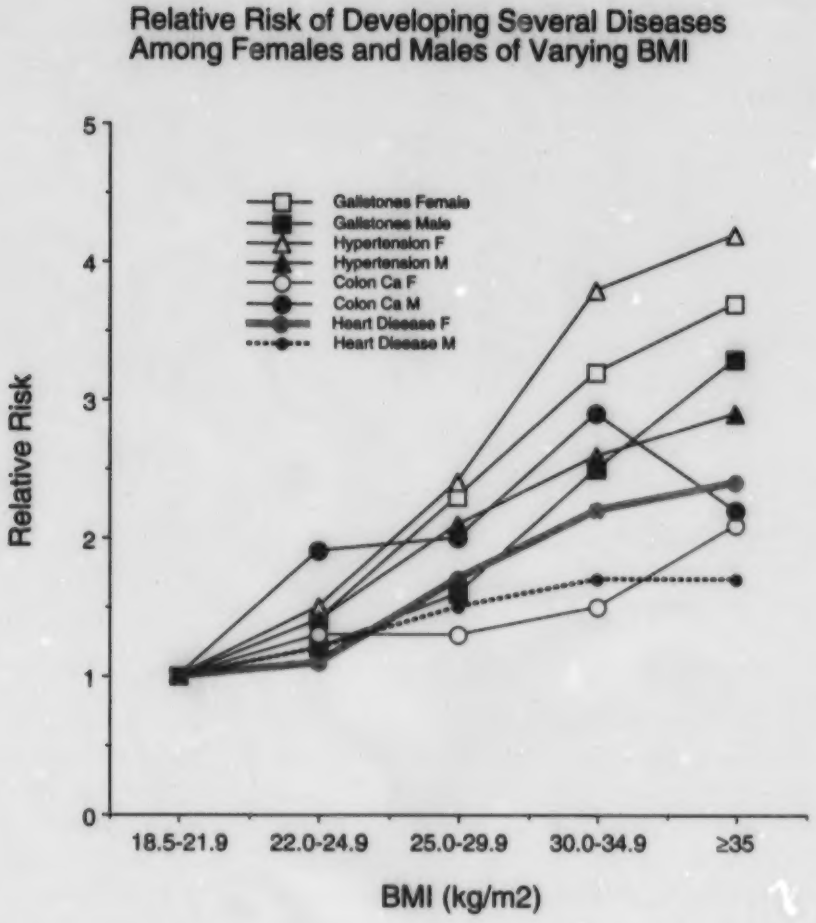


Figure 2

In 1996-97 19% of Canadians had a BMI between 25.0 and 26.9 and 29% were overweight to the point of a probable health risk with a BMI of ≥27. Of those with ≥ BMI 27, the highest percentage occurred with an education of less than high school (36%) and the lowest with an university education (22%). There were more with BMI ≥ 27 in the highest income group (~ 20%) and a progressive decrease to those in the lowest income group (~14%). There were relatively small differences for those with BMI ≥ 25 among income groups. The age and sex distribution is given in Figure 3.

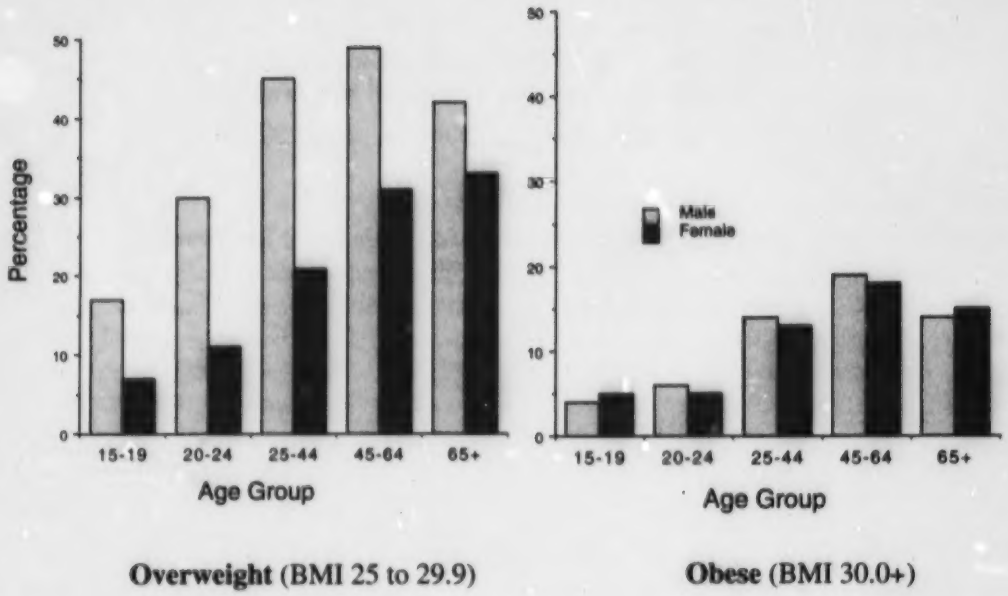


Figure 3. Percentage of population aged 15 or older who were overweight or obese, by age group 1998/99 (Adapted from Health Reports 2001 Vol 12, No. 3, page 17, Statistics Canada)

Three % or close to 1 million Canadians have diabetes, and this is probably an underestimate as a sizable number of people with the disease are unaware of it and when compared to surveys in the United Kingdom and the US. The percentage with diabetes rises steadily with age rising from 0.5% for ages 12-34, 3.2% for ages 35-64 and 10.4% for age 65+ (12.1% for age 65+ males). About 90% are type II diabetes, now shown to be preventable. Economic costs per year have been estimated at nearly 14 billion dollars.

A clinical trial has shown that type II diabetes can be prevented by modest lifestyle changes in high risk people. (Tuomilehto, J et al. Prevention of type 2 diabetes mellitus by changes in lifestyle among subjects with impaired glucose tolerance. N Eng LJ Med 2001; 344:1343-50). The study examined 522 middle-aged, subjects, mean age 55 years, and mean body-mass index 31kg/m^2, with impaired glucose tolerance, assigned to either an intervention group or control group. Each subject in the intervention group received individualized counselling aimed at reducing weight, total intake of fat, and intake of saturated fat and increasing intake of fibre and physical activity. An oral glucose-tolerance test was performed annually; the diagnosis of diabetes was confirmed by a second test. The mean duration of follow-up was 3.2 years. During the trial, the risk of diabetes was reduced by 58 percent ($P<0.001$) in the intervention group.

The reduction in the incidence of diabetes was directly associated with changes in lifestyle. The extent of lifestyle changes were modest and shown in the table below, adapted from the publication.

SUCCESS IN ACHIEVING THE GOALS OF THE INTERVENTION BY ONE YEAR, ACCORDING TO TREATMENT GROUP.

GOAL	INTERVENTION GROUP	CONTROL GROUP	P VALUE
	% of subjects		
Weight reduction >5%	43	13	0.001
Fat intake <30% of energy intake	47	26	0.001
Saturated-fat intake <10% of Energy intake	26	11	0.001
Fibre intake ≥15 g/1000 kcal	25	12	0.001
Exercise >4 hr./wk. *	86	71	0.001

* Exercise at least equivalent to: "I walk, cycle, or exercise lightly in other ways at least four hours per week ".

Cancer

Cancer is the cause of the greatest number of years of life lost before age 75, exceeding even heart disease and strokes combined (see Figure 4). Using 1998 Canadian figures, the most common site of new cancer among men (Figure 5) was the prostate (16,100 estimated cases, compared with 12,200 new lung cancer cases). After lung and prostate, colorectal cancer is the next most common. However, deaths due to lung cancer among men (an estimated 10,600) will far exceed the deaths due to prostate cancer (4,300). About 1/3 of all cancer deaths are due to lung cancer in men. The lifetime risk of dying from all of colorectal, bladder, lymphoma, oral, stomach, kidney, leukemia, pancreas, and melanoma malignancies is about 85% of that of lung cancer. The risk of dying from prostate cancer is about 45% of that of lung cancer.

Among women, breast cancer was the most common newly diagnosed cancer (19,300 estimated cases), followed by lung (8,200) and colorectal cancer (7,600) (Figure 6). The leading cause of cancer death for women, however, will be lung cancer (6,500 deaths in 1998, compared with 5,300 for breast cancer). About 1/4 of all cancer deaths for women are due to lung cancer. Other cancers in both men and women fall substantially behind lung, breast, prostate and colorectal in incidence and causes of mortality.

The mortality rate from cancer for women is about two-thirds that of men partly due to the incidence of lung cancer in men. However the incidence of lung cancer for women has been rising for most of the past 30 years while the incidence in men has been slowly declining for about 15 years.

Of the various cancers, lung cancer is almost entirely due to cigarette smoking, making it an almost totally preventable disease. Smoking is also an important factor in most cancers, although not as strongly as with lung cancer and cancers of the mouth, lip, throat and larynx.

Dietary habits play a role in promoting some cancers as does exposure to high levels of X-rays and radon, some chemicals and pesticides, infection with the Human Papilloma Virus (HPV), the Human Immunodeficiency Virus (HIV), Hepatitis B virus, probably exposure to excess sun, air pollution and second hand tobacco smoke. Some of these are clearly preventable such as the infectious causes and exposure to carcinogenic radiation and chemicals. Many of the dietary habits associated with lowered risk of heart disease and hypertension are considered favorable to reduce the risk of some malignancies.

A powerful and informative study based on an extensive analysis of Swedish, Danish and Finnish monozygotic and dizygotic twins concluded "Inherited genetic factors make a minor contribution to susceptibility to most types of neoplasms". (Lichenstein P, et al. Environmental and heritable factors in the causation of cancer. N Eng J Med 2000;343:78-85). Cancers where inherited effects were larger were prostate (42%), colorectal (35%), and breast (27%) cancers. While this study does not comment on random mutations acquired over the years it does indicate strongly that most cancers are not inherited.

The use of the Pap smear for prevention of cervical cancer mainly from HPV infection has been one of the great success stories of modern prevention but could be even better done. In 1996-97 about 83% of women had a Pap smear within the last 3 years, Never having a smear is most common in those with less than a high school education. Prevalence of a mammogram within the last 2 years in women over age 50, a proven early detection strategy for breast cancer, reached 75% in 1996-97. By far the commonest reason for not having one was the view, "Didn't think it was necessary".

Rate of potential years of life lost (PYLL) before age 75, selected causes of death, 1997

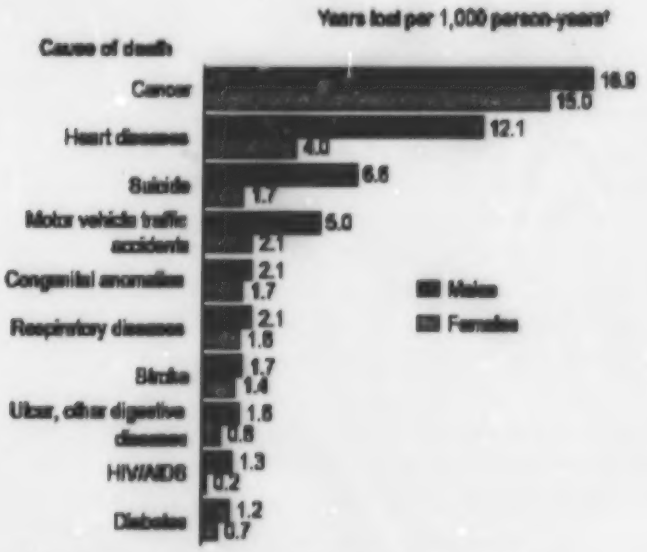


Figure 4

Data source: Canadian Vital Statistics Database
† Standardized to 1997 Canadian population

Figure 5

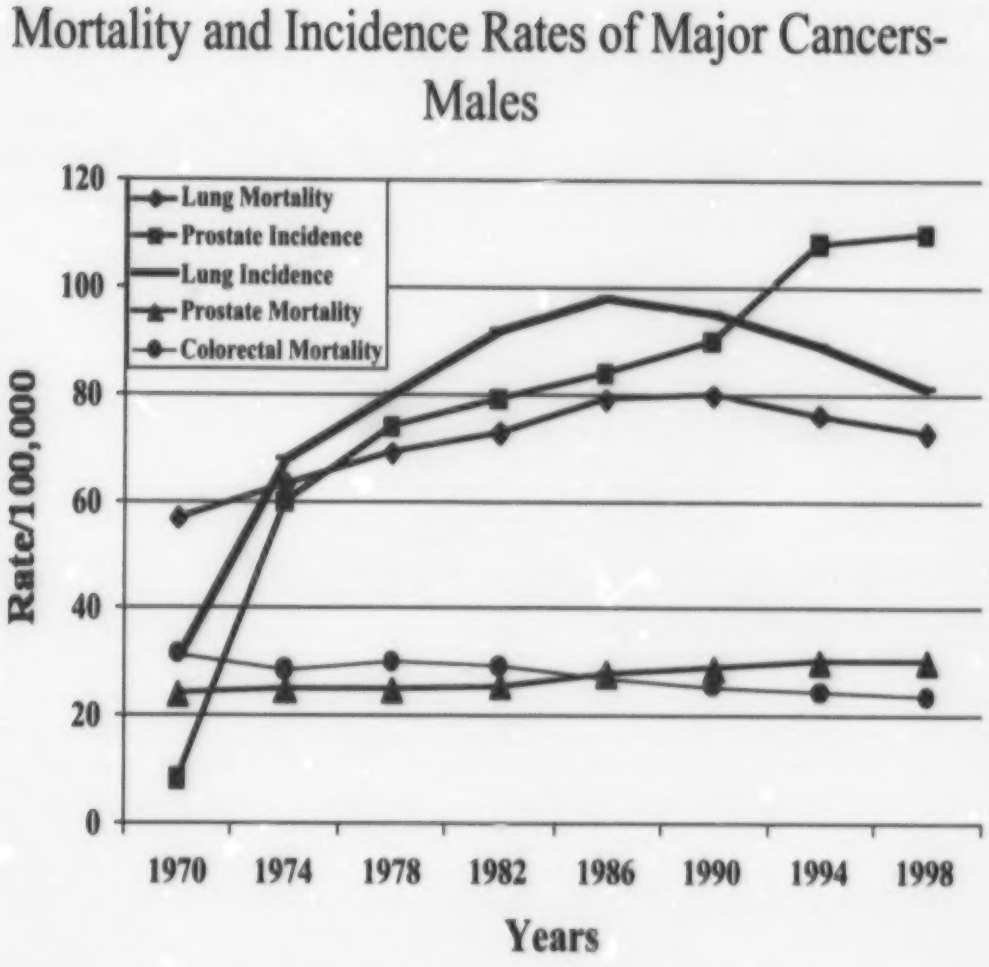


Figure 5 Source: National Cancer Institute of Canada, Canadian Cancer Statistics 1998, Toronto: National Cancer Institute of Canada, 1998 (1998 estimated)

[Note - the incidence of prostate cancer peaked in 1993 at about 138 cases per 100,000 and declined in 1995 to about 109 cases per 100,000 due to a large number of new cases from use of the Prostatic Specific Antigen (PSA) test.]

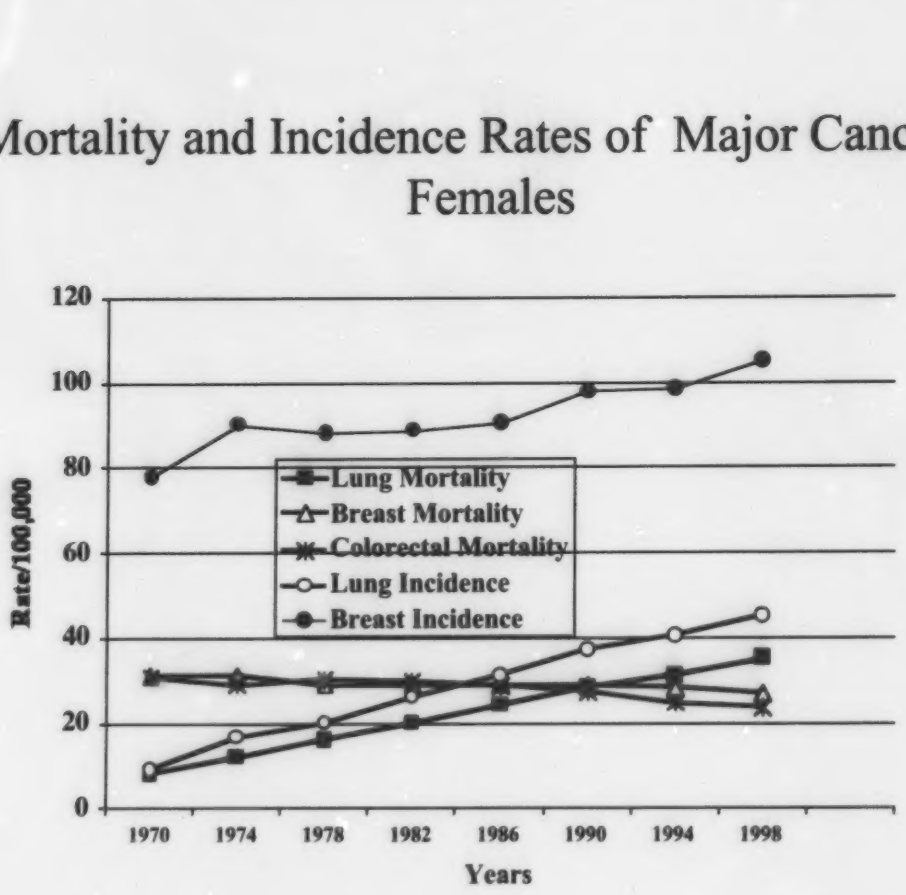


Figure 6 Source: National Cancer Institute of Canada, Canadian Cancer Statistics 1998, Toronto: National Cancer Institute of Canada, 1998 (1998 estimated)

Chronic Lung Disease

Chronic lung disease is the fourth most common cause of death in Canada. The vast majority of this illness is strongly associated with smoking. Elimination of smoking would prevent almost all chronic lung disease or markedly improve cases not prevented.

Unintentional injury with comments on alcohol consumption

The fifth most common cause of death in Canada is unintentional injury. However when examined by years of potential life lost before age 75 motor vehicle "accidents'" are number four because of the much higher incidence among young people especially males (see Figure 4). Major factors responsible for serious unintentional injury are related to drinking, driving after drinking and failure to use seat belts and helmets especially for bicycle injuries. Numerous factors in the home contribute to uninten-

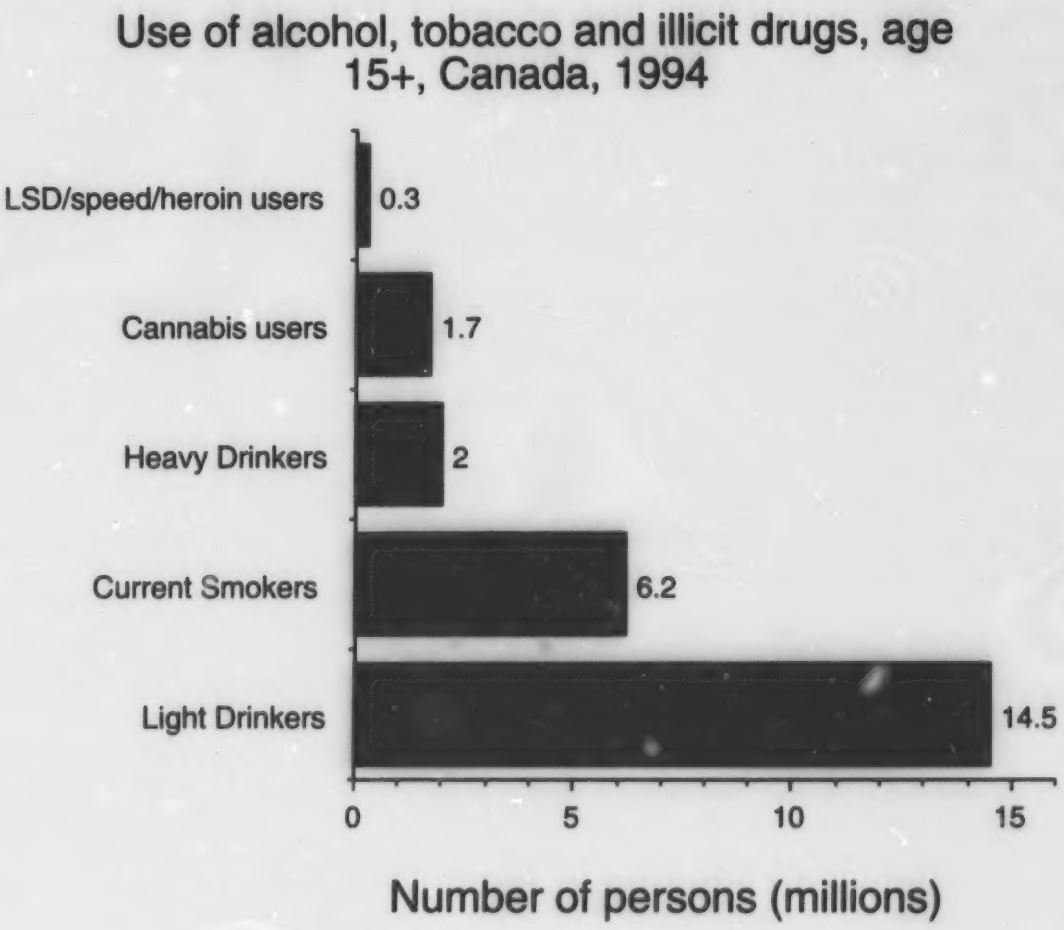
tional injury. Drinking is also a factor in other situations such as violence to others, other types of "accidents", and various social problems including unstable homes.

Injury is most common in the 12 to 24 yr. age group with the 25 to 44 age group next. Injuries in the 45-65 and 65+ group were significantly lower and similar to each other in percentages. Overall strains and sprains were by far the most common with broken bones next. The home or nearby is the most common site followed by a recreation site, and then the street or highway. For men an industrial site was a common location. Commonest causes were falls, number one by far, followed by being struck by an object, next a natural environment factor and then motor vehicle accidents which had the most serious outcomes overall. Work related injuries are common among both men and women.

About 10% of all Canadians drive after drinking once or more times per year, 13% of males do so and only 5% of females. The problem is worst among the 18-19 yr. group where 17% of males did so and 19% of females. The problem continues high for 20-24, 25 to 34 and 35 to 44 yr. age groups, with the percentages being 16, 12 and 11 respectively. However in these age groups the problem is mainly males where 22, 17 and 17% drove and drank one or more times a years. Corresponding numbers for females were 8, 7 and 5% . There was no association with education. Motorists over 16 who always arrange for a designated driver when attending an event where alcohol will be consumed varied substantially be province ranging from 75% in Nova Scotia to a low of 48% in Quebec compared to a national average of 60%. Alberta was at 58%.

Binge drinking (5 or more drinks at one session) is also much more common among males, with 9% of males doing so 1 or more times per week and 3% of females. It is commonest among 18 to 24 yr. olds with about 17 to 18% of males doing so compared to 7% of females. Binge drinking was more likely in those with less than high school education. The most common response from those who had quit drinking was that they had been "drinking too much" (40%). Almost one-quarter (22%) had quit because drinking was affecting their physical health, and one in six (17%) quit drinking because it was affecting their family. Treatment of excessive drinking is often successful (Fleming MF et al. Brief physician advice for problem alcohol drinkers. JAMA;277:1039-1045; O'Connor PG, Schottenfeld, RS. Patients with alcohol problems. N Eng J Med;337:1705-1714.)

The next figure (Figure 7) sets in context the magnitude of the problem of several behaviours. Light drinkers are by far the most numerous but light drinking is not a known health hazard and in older people promotes reduced heart disease. The next most common group, 6.2 million smokers, is a crushing health risk and outnumber heavy drinkers (2.0 million) and cannabis (1.7 million) users combined. There are clear health and serious social risks to heavy drinking but health risks for cannabis use are limited or poorly defined. Heavy drug users represent 0.3 million users and pose numerous health and social risks including heightened risk for HIV and hepatitis infection.



Source: MacNeil P, Webster I, Canada's Alcohol and Other Drugs Survey: A Discussion of the Findings, Ottawa: Minister of Public Works and Government Services Canada, 1997

Figure 7

About 29% of Canada's 6 million cyclists claim to always wear a helmet when riding a bike. If those who often wear a helmet are included, this figure rises to only 36%. However, the number of cyclists wearing helmets is up significantly from 1994–95, when only 19% always wore a helmet and only 23% always or almost always wore a helmet when riding. The largest proportion by far (59%) reported that they never wear a bicycle helmet but this is down from 1994–95 when 73% never wore helmets while cycling. Differences in helmet use associated with education are very pronounced. There is an almost 2.5-fold difference between the least and most educated groups — one of the steepest gradients related to education of all the topics in the Statistical Report. Higher incomes groups are more likely to wear helmets.

Eighty-six percent of Canada's 18.7 million motorists age 16 and older reported that they always insist that all passengers are safely fastened with seatbelts (including children in car seats). About 94% of motorists always or often insisted that their passengers wear seatbelts. Only 4% of Canadian motorists rarely or never insisted on such precautions. However, only 60% of men age 20–24 always insisted on their passengers wearing seatbelts, the lowest level of all age and sex groups; in fact, 17% of these men rarely or never insisted on the use of seatbelts, the highest level of all age and sex groups. Overall, almost 90% of Canadian motorists age 45 and older always insisted on their passengers wearing their seatbelts. Unlike helmet use, there was not an association with education, and the slight trend with income was reversed with the highest income group using seatbelts a little less than the lowest income group.

Suicide and Mental Illness including depression

Suicide is the third highest cause of years of life lost before age 75 for males and fourth for females. Psychoses are the 10th most common cause of death for females. Mental disorders were the eighth most common cause of hospitalizations for Canadians in 1995-96, just a little less than neoplasms. Of these about 23% are due to affective disorders and 12% to alcohol and drug dependence. About 4 to 6% or about 1 million of Canadians report a major depressive illness in a given year. Depression is more common in the young and females but the duration is longer after age 75. Depression is most common in the lowest income group (~9%) and least common in the highest income group (~3%). Overall mental disorders of various types affect 20% of children and adults. About 2/3 of homeless people are likely to have mental disorders.

Mental illness is also a major cause of disability and occupies 5 of the 10 leading causes internationally (major depression, schizophrenia, bipolar disorder, alcohol use disorder and obsessive compulsive disorder).

Risk factor prevalence for some major diseases

The major diseases just discussed are associated with major risk factors which in many cases have a causal relationship. This section looks at distribution of some of the most critical of these: dietary choices, activity levels, weight control, and smoking. Some of the risk factors for unintentional injury and mental illness have been covered under those topics.

Diet

* A large percentage of Canadians do **NOT** choose or avoid foods because of worry of heart disease, high blood pressure, diabetes, or cancer. For example, among men only 37%, 24%, 17% and 23% **did** choose or avoid foods because of concern for heart disease, high blood pressure, diabetes and cancer respectively. Among women the numbers were 47%, 28%, 24% and 32%. Significantly higher percentages do choose or avoid foods once diagnosed with an illness. Women are more likely to select foods based on health concerns. In the case of body weight only 49% of males with a BMI ≥25 selected foods with consideration for their effect on weight whereas about 68% of women did so.
* Fat in the diet - 41% of Canadians (≥ 12 yrs.) are either not concerned (32%) or concerned but taking no action (9%). For those with less than high school the values are 49% (not concerned

40%, concerned but no action 9%) and for those with university the values are 25% (not concerned 17%, concerned but no action 8%). Less than one-half the population knows the term saturated fats, <40% polyunsaturates, <25% monounsaturates, and ~10% omega-3 fatty acids.

* There is little information on the ability of, or action, of Canadians to select food of a more complex nature but shown to have either positive effects on health such as elevated folic acid, enriched calcium and vitamin D content, reduced glycemic load and elevated fibre content, reduced sodium content, and foods rich in potassium, or a negative effect such as trans fats and elevated glycemic index.
* The Canada Food Guide is outmoded and far too general to provide guidance on balance and optimization of food – based on evidence from major studies of diet on health. It fails to adequately distinguish between food groups. For example, legumes are placed with meats because both contain protein but otherwise they are about as dissimilar as possible, while whole grain products are poorly distinguished from highly refined grain products.
* Most knowledge of food comes from food marketing and some from nutritional experts that represent marketing boards. These individuals frequently present results of studies funded by commercial enterprises, sometimes their employer, or present selected studies and not an overview

Exercise (Activity)

According to the National Population Health Survey, 57% of Canadians >12 yrs. of age were inactive (<1.5 kilocalories per kilogram body weight). Of those with less than high school education, 61% were inactive versus 47% with university education. Those in the highest income group and males were more likely to be active. Jobs can provide activity demands but fully 25% of Canadians sit at work, close to half spend considerable time standing or walking with about 20% doing lifting and carrying light loads. About 6% do heavy labor.

Examination of the following figure (Figure 8) illustrates the marked drop off in leisure time activity as people get older. Almost every major good quality study on activity and health whether it be longevity, disability, heart disease, diabetes, osteoporosis and even some cancers has shown a beneficial effect of activity equivalent to brisk walking. (One example, Hakim AA et al. Effects of walking on mortality among nonsmoking retired men. N Eng J Med 1998;388:94-99). Older individuals continue to benefit and the most active live the longest with less disability. Reduced activity with age is also a factor in the increasing prevalence of obesity.

Weight control

See also Diabetes and other Chronic Diseases – the relationship to Body Mass above. Weight control is almost entirely a function of dietary intake and exercise. See also diet and exercise sections.

Smoking

In 1998-99 23% of Canadians smoked (see the following figure for distribution by age). There was a powerful relationship with education in the 1996-96 NHPS in that 39% of those with less than high school education smoked compared with 14% with an university education. However, the incidence of former smokers was not associated with education with 26% among those with less than high school education and 27% in those with university. Smoking prevalence also varied sharply by income (1998-99). People in the lowest income households were nearly twice as likely to be current smokers (30%)

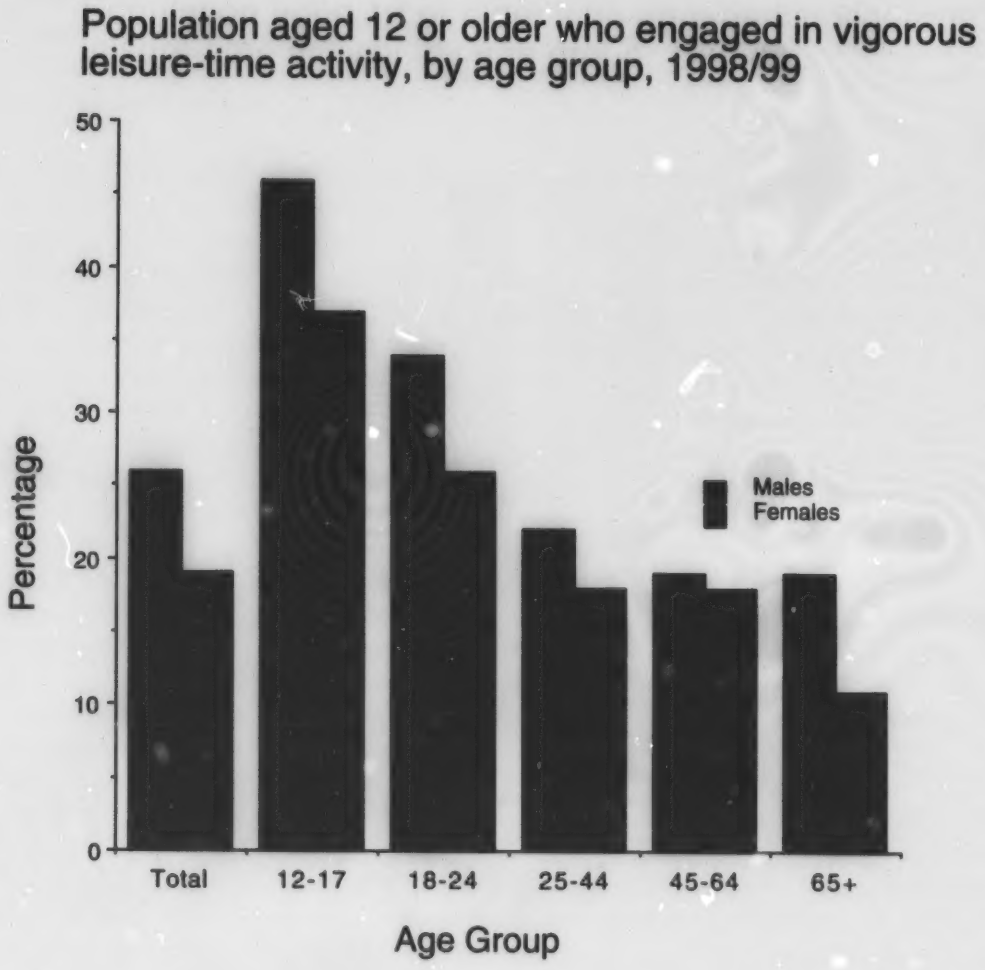


Figure 8 Source National Population Health Survey, household component

as were those in the highest (16%). In contrast, the likelihood of smoking initiation or quitting did not vary by income.

In general the incidence of smoking was somewhat less among females (see Figure 9) except for the ages 15 to 17 where 29% of females smoked versus 22% of males. Peak years for smoking were from 18 to 44 with a general decline among older age groups. To appreciate the problem note that there were 6.2 million smokers in Canada in 1994 compared to 2 million heavy drinkers, 1.7 million canabis users, and 0.3 million LSD/speed/heroin users.

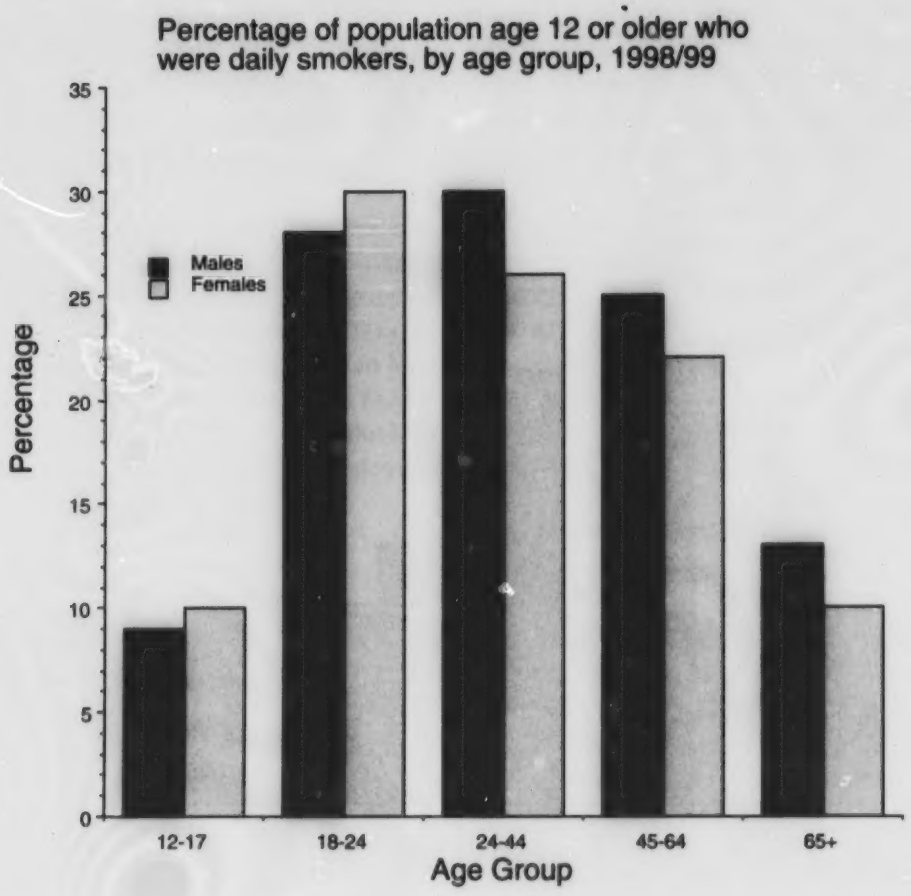


Figure 9 Source National Population Health Survey, household component

The relationship of smoking to multiple diseases is well established. The vast majority of Canadians recognize the risk of smoking for lung cancer (97%), respiratory ailments (i.e., emphysema/bronchitis/ asthma) (95%), heart disease (94%), and stroke (85%). The risks are well known even among 12-14 yr. olds – lung cancer (99%), respiratory ailments (i.e., emphysema/bronchitis/asthma) (93%), heart disease (95%), and stroke (85%). The effects of environmental smoke are somewhat less accepted with skepticism about health risks ranging from ~7% in Quebec to ~2% in BC. Risk from environmental smoke is accepted for lung cancer (80%), respiratory ailments (i.e., emphysema/bronchitis/ asthma) (84%), heart disease (72%), and stroke (58%) with no risk accepted by 14%.

Recently there has been less progress than desired in reducing the number of people who start smoking. The group with the highest start rate was 12 to 17 year olds. Of those smoking in 1994/95, 72% were still smoking in 1998/99. Strategies have centered on advertising bans and some anti-smoking advertising directed at young people, higher taxation, package labelling, restricting sales to youth, and various changes in legislation. Most investigators conclude a comprehensive program requiring multiple levels of intervention and involvement of government and non government agencies is needed. In

Reducing Tobacco Use, David Satcher, MD, PhD Surgeon General of the United States, (http://www.cdc.gov/tobacco/sgr/sgr_2000/sgr_tobacco_chap.htm), set out the parameters for effective domestic action. Research shows that tobacco use can be reduced through a comprehensive approach including education, community and media-based activities, pharmacological treatment of nicotine addiction, regulation of advertising and promotion, clean air regulations, restriction of tobacco sales to minors, and taxation of tobacco products.

Taxation and youth directed advertising have often been found to have an effect. Advertising in Canada has not been effective, at least by one major assessment. It has been proposed that the highly cost effective Vermont campaign could be used as a model for future efforts. Next in order of cost effectiveness were California, Massachusetts, and Florida (because behavioural outcomes in these states were inconsistent across time and/or grades). The type of advertising is important - industry manipulation and second-hand smoke have been the most effective strategies. Addiction and cessation can be effective when used in conjunction with the industry manipulation and second-hand smoke strategies. Youth access, short-term effects, long-term health effects, and romantic rejection are not effective advertising strategies. (Pechmann C, Reibling ET. Anti-smoking advertising campaigns targeting youth: case studies from USA and Canada. Tob Control 2000;9 Suppl 2:II18-31, Goldman LK, Glantz SA. Evaluation of antismoking advertising campaigns. JAMA 1998; :279:772-7)

Considerable progress has been made in the success of smoking cessation programs directed at individuals. A comprehensive program of pharmacological treatment and counselling provided by family physicians or other counsellors has reasonable success. (The Tobacco Use and Dependence Clinical Practice Guideline Panel, Staff, and Consortium Representatives. Clinical Practice Guidelines for Treating Tobacco Use and Dependence A US Public Health Service Report JAMA. 2000;283:3244-3254). Nicotine replacement therapy and much of the counselling is not covered by Canadian health plans at present.

As noted above there are other steps that can be taken, among the most important are stricter efforts to prevent tobacco sales to underage children (request for age verification strongly predicted compliance with the law in a US study, (JAMA 2000;284:729-734), encouragement of parents with minor aged children to adopt smoke-free homes, smoke-free workplaces can also augment smoking prevention (JAMA 2000;284:717-722), school based smoking prevention programmes; and an increase in the passage of local ordinances that create smoke free indoor environments and reduce cigarette sales to youth. (Wakefield M, Chaloupka F. Effectiveness of comprehensive tobacco control programmes in reducing teenage smoking in the USA. Tob Control 2000 Jun;9(2):177-86).

School programmes that have been carefully evaluated have been disappointing in their lack of effectiveness with respect to long-term impact on prevention of smoking. The best of these, the Hutchinson Smoking Prevention Project (HSPP), conducted from September 1984 through August 1999, aimed to attain the most rigorous randomized trial possible to determine the long-term impact of a theory-based, social-influences, grade 3-12 intervention on smoking prevalence among youth. Forty Washington school districts were randomly assigned to the intervention or to the control condition. Study participants were children enrolled in two consecutive 3rd grades in the 40 districts (n = 8388); they were followed to 2 years after high school. Consistent with previous trials, there is no evidence from this trial that a school-based social-influences approach is effective in the long-term deterrence of smoking among youth. (Peterson AV Jr, Kealey KA, Mann SL, Marek PM, Sarason IG. Hutchinson Smoking Prevention Project: long-term randomized trial in school-based tobacco use prevention—results on smoking. J Natl Cancer Inst 2000;92:1979-91).

Determinants of Health

Population Health – Social, economic, educational and health gradients

There has been a good deal of work showing that economic and social factors such as income and prosperity, employment, education, social gradients, social environment, physical environment and early childhood development influence health status. (See also the following section Populations - Social, economic and educational gradients and health). These are often referred to as the Determinants of Health". Results from recent National Population Health Surveys continue to provide support for their role to a greater or lesser degree. **However of major importance the survey results show there is no association between income inequality and mortality at either the provincial or metropolitan level In Canada.** (How Healthy are Canadians, Health Reports, 2000, Vol. 11, No. 3, Statistics Canada).

Despite the lack of association between income and mortality, many relationships were brought out by that report and Health Reports, 2000, Vol. 11, No. 3, Statistics Canada, 2001, Vol. 12, No.3.

INCOME RELATIONSHIPS:

Lower prevalence in lower income

* BMI ≥ 27 is higher in the highest income group (~ 20%) with a progressive decrease to those in the lowest income group (~14%).
* For seatbelt use the slight trend seen with income was reversed with the highest income group using seatbelts a little less than the lowest income group

Higher prevalence in lower income

* Income-related disparities in infant mortality are two-thirds higher in the poorest neighborhoods than the richest.
* Smoking prevalence varied sharply by income (1998-99). People in the lowest income households were nearly twice as likely to be current smokers (30%) as were those in the highest (16%).
* Higher incomes groups are more likely to wear helmets for cycling.
* Those with low incomes were more likely than those with higher incomes to: be heavy users of physician services, visit emergencies, be admitted to hospital, take multiple medications and require home care services.
* Depression is most common in the lowest income group (~9%) and least common in the highest income group (~3%).
* Seniors with low incomes have increased odds of institutionalization

No relationship to income

* The likelihood of smoking initiation or quitting did not vary by income.

EMPLOYMENT

* Life expectancy increase as the rate of unemployment decreases.

EDUCATION RELATIONSHIPS:

* Life expectancy increases as the level of education increases
* Children whose parents have a low level of education are more likely to have poorer perceived health and less likely to enjoy unbroken good health
* Differences in helmet use for cycling associated with education are very pronounced. There is an

almost 2.5-fold difference between the least and most educated groups — one of the steepest gradients related to education of all the topics in the Statistical Report

* Smoking - 39% of those with less than a high school education smoke compared to 14% with an university education.
* Activity - of those with less than high school education, 61% were inactive versus 47% with university education.
* ≥ BMI 27, the highest percentage occurred (36%) with an education of less than high school and the lowest percentage with an university education (22%).
* Hypertension is most common in those with less than high school (12%) and least in those with university (8%) education
* Never having a PAP smear is most common in those with less than a high school education
* Binge drinking was more likely in those with less than high school education.
* Seniors who did not graduate from high school have increased odds of dying relative to their age group

Lack of correlation with education

* The incidence of former smokers was not associated with education in that there 26% among those with less than high school education and 27% in those with university.
* Canadians who drive after drinking once or more times per year – no correlation with education

ABORIGINAL POPULATIONS

* Regions of Canada with the lowest life expectancies tend to be in remote or northern regions and have significant Aboriginal populations.

SEX AND AGE (AND OTHER ASSOCIATED ASSOCIATIONS)

* Depression is twice as common in women as men and much more common in older women with higher odds for those lacked emotional support. There is also a strong association between smoking and depression.
* The likelihood of going to hospital increases with age, having a lower income, having less than secondary education, believing oneself to be in poor health, and being a smoker, physically inactive or overweight.

Proposal for Action:

The preceding provides an overview of the opportunity to potentially improve the health of Canadians. I recommend two broad approaches to take advantage of some of these opportunities. These would be directed at populations of people and individual behaviours.

Determinants of Health: Population actions - Social, economic and educational gradients and health.

It has been established that a number of social and economic factors including those that relate to the wealth production of a country and the distribution of that wealth contribute significantly to the health of a population. Gradients in health are seen to differing degrees in association with income, education, work status, class and social inequalities. These have been summarized in a number of publications including a highly influential one by Mustard and Frank in 1991 entitled "The Determinants of Health" (Canadian Institute for Advanced Research, 179 John Street, Suite 701, Toronto, ON, M5T 1X4).

Surveys such as the National Population Health Survey (NHPS) are not the ideal way to examine the effects of the social and economic environment on health as they are not designed to assess the many variables that confound interpretation of correlation's detected, but they are a practical and reasonably effective way to look at changes over time. The surveys reveal some observations of importance to advance future health in Canada.

An extremely important observation is that clear progress between income disparity and mortality has been achieved in that there is no association between income inequality and mortality at either the provincial or metropolitan level in Canada according to How Healthy are Canadians, Health Reports, 2000, Vol. 11, No. 3, Statistics Canada.

However a number of subgroups of health status do show a correlation with certain economic, social or educational gradients. These are summarized earlier in the paper but several are worthy of note.

Income: Infant mortality is higher in poorest neighbourhoods, smoking prevalence is much higher in lowest income households, and there is greater depression and greater rates of senior institutionalization in lowest incomes groups. Those with low incomes were more likely to be heavy users of physician services, visit emergencies, be admitted to hospital, take multiple medications and require home care services. Of some significance is the reverse trend for BMI $\geq$ 27 which is higher in the highest income group.

Employment: Life expectancy increases as the rate of unemployment decreases.

Education: Lowest levels of education are associated with lowered life expectancy, greater physical inactivity, much higher prevalence of smoking, a higher prevalence of BMI $\geq$27, more hypertension, increased odds of dying among seniors (age adjusted), greater binge drinking, a much lower probability of wearing a cycling helmet and children whose parents have a low level of education are more likely to have poorer perceived health and less likely to enjoy unbroken good health.

Aboriginal population

Regions of Canada with the lowest life expectancies tend to be in remote or northern regions and have significant Aboriginal populations. In fact some of the correlations with income in particular are related to the extent of aboriginal population in a region.

Multiple associations

The likelihood of going to hospital increases with age, having a lower income, having less than secondary education, believing oneself to be in poor health, and being a smoker, physically inactive or overweight.

Depression is twice as common in women as men and much more common in older women and with higher probability for those who lacked emotional support. There is also a strong association between smoking and depression.

Conclusion:

The relationship of certain social, economic and educational gradients with health status demonstrated by the three NPH Surveys are of great enough significance that specific recommendations for ways to reduce their magnitude are warranted.

Recommendations

1. The Alberta government should institute or enhance its efforts to ensure an optimal environment for early childhood and childhood development. Several programs are under way by the Ministry of Children's Services in Alberta and across Canada (See Appendix 1). Because of the profound influence of education on health every effort should be made to ensure all children have the fullest opportunity possible to complete high school and a post secondary program of some type (if physically and mentally feasible) whether it be in a university, college, technical school or other recognized post secondary educational institution.

   It is proposed that a "Total Education" theme be developed for all young children. This effort should ensure the financial capability and other resources necessary to guarantee access to existing pre-kindergarten "educational development programs", kindergarten, primary, secondary and post secondary programs. The Ministry of Children's Services should be charged with monitoring all children in the province to ensure their enrolment and maintenance of enrolment and to develop data bases to recognize failure of enrolment. All failures or questionable failures should be flagged and early investigation carried out to determine the reasons for such failure and mechanisms to overcome the failure put in place wherever reasonable. Appropriate financial or other assistance for children in poverty and low income homes should be provided.

2. The Alberta government should support the federal policies directed to reduction of social, economic, and class gradients in Canada, and wherever deemed reasonable, improve upon these.
3. The Alberta government should work with industry and business organizations to enhance the safety of and equality within the work environment.
4. The Alberta government should continue policies to clean up the environment and ensure as safe a physical environment as possible.
5. The existing policies of immunization and prevention of infectious disease including safe water and food should be given high priority and support by the Ministry of Health and Wellness. A section of the provincial epidemiology service should be devoted to ensure a capability to respond to emerging infectious disease (in concert with federal and international resources).
6. Both levels of government should continue and, if feasible, enhance efforts to diminish unintentional injury and violence through strategies to diminish binge drinking, risk factors for auto accidents in the young and old, and efforts to target and assist those at higher risk for suicide.

Individual behaviours

A main section of the report has documented the extensive opportunity for better health whether it be longer life, less disability, or reduced morbidity from individual illnesses. Recent studies have shown the power of lifestyle changes to markedly reduce the incidence and severity of several major disease but especially heart disease, stroke, hypertension, diabetes, and selected cancers. Many of the lifestyle modifications are relatively modest but have not been as widely taken up as desirable for optimal health. The reasons for this are complex and include confusion over optimal choices, a desire to not be dictated to by government or other authorities, failure to accept the validity of the risk, low priority compared to the other demands of life, a lack of a sense of personal control of one's life, peer pressure, dealing with excessive stress of daily life, and others. To provide new opportunity, innovative approaches, as well as continuation of some shown successful, need to be undertaken.

Conclusion:

The opportunity for improved health and probably reduced demand on health services is enormous through modest modification of lifestyle of a large number of individuals. The complexity of reasons for failure of wider acceptance of optimal lifestyles for health demands a broad and innovative approach. However the potential for added value is so high that several approaches need to be explored in depth and examined on significantly sized population groups. Small scale pilots are not recommended.

Recommendations:

Incentives

1. Tax deductions or tax credits or credit against health premiums for the cost of personal or family health promotion programs should be provided. These programs should be developed using a format of general principles created by the Ministry of Health and Wellness that are approved for content by a panel of appraisers appointed by Alberta Health. The programs should be administered by private not-for-profit or for-profit organizations. Mandatory minimal "attendance" would be a requirement to receive financial credit. For individuals or families below a defined income level, reimbursement would be directly provided to the program providers
2. Medical Savings Plan. The introduction of one or more Medical Savings Plans (MSP) should be carried out and tested in a significant population centre. In principle these would entail a sum of money provided to each person and which could be spent on broadly defined health services below a maximum amount after which catastrophic health insurance would "kick in". Details of such plans are anticipated in another section of the Council's recommendations. An approved expenditure should be allowed and strongly encouraged for personal or family health promotion programs (or from the annual amount remaining and not spent on health services) of a MSP. This usage would be likely be part of an overall MSP program to give greater consumer choice. However, priority should be built in to emphasize enrolment and completion of a health promotion program,
3. Joint programs of government with business to encourage enrolment in and completion of an approved personal or family health promotion program whereby joint contributions would be made by the Alberta Government through partial tax credit or tax deduction or credit against a health premium (or from a Medical Savings Plan) and by a business through partial reimbursement either with cash or by providing a partially subsidized approved program on site.

4. A. Smoking cessation and drug cessation programs – full reimbursement of costs of approved programs and associated drug costs should be provided providing the program was completed and a minimum period of short term smoking cessation achieved.
   B. Reimbursement of drug costs for smoking cessation.
   C. A fee item for smoking cessation counselling for MDs or other approved counsellors. (See also section on smoking programs).
5. The introduction of a fee item for health promotion for MDs and other practitioners, where appropriate, would encourage greater provision of health advice and counselling from primary care practitioners.
   Alternatively a wide change in payment structure for primary care physicians, and to a lesser degree, other health providers should be instituted. The payment system most widely considered to have value to enhance health promotion is a capitation scheme (or possibly a salary scheme) ideally involving a broad range of health care providers including nurse practitioners, nutritionists, fitness instructors, counsellors of different type, and perhaps others. This change has many arguments in its favour but it would require a number of years at the minimum to institute. Thus shorter term changes like a fee item should be considered in the interval. The discussion of a capitation or salary scheme for health providers is topic unto itself and will not be further discussed here.

"Informationist" role including program for personal health plan

1. Alberta Health and Wellness should have a permanent "Informationist" section to review new studies of lifestyle and health, analyze as to quality and significance and synthesize into clear, easy to use, and short guidelines. These would be updated as a general publication every 6 months to 1 year using validated studies synthesized into a short, easy to understand, and to use summary.

   The need for this service is due to the flood of information from many sources almost all of which is unevaluated or not prioritized as to significance and is often presented by commercial interests or experts with ties to industry. The net effect is a failure for the general public to recognize which steps are key and crucial out of the many "advances" reported and that undertaking such steps is often a modest lifestyle change.

2. Using the information from above a primer for the general public and health providers outlining a plan or plans for optimal personal health should be created summarizing the best information in areas of diet, exercise, smoking cessation, alcohol and drug use, stress and personal control, and defensive behaviours to prevent infection, unintended injury, and suicide and to improve early detection of disease.

A mandatory formal health theme in the school curriculum.

1. In view of the early onset of major chronic diseases especially atherosclerosis and the rapidly increasing prevalence of excess weight in children, a formal health theme should be started in kindergarten/grade 1 and be continued through grade 12 and be an essential part of the curriculum. It should incorporate both cognitive and physical components. The content should be based on up-to-date studies evaluated and synthesized by the "informationist" section of Alberta Health and Wellness. Among the topics should be: healthy eating: minimal exercise for health; defensive behaviours to minimize unintentional injury, suicide, infection, and promote early detection of ill-

ness; actions that reduce the risk of cancers; proper use of alcohol; and the effects of tobacco use and drug use.

2. Regular exercise periods should be part of every school day tailored to the interest and capabilities of the student.

Concerted program for tobacco reduction

Research shows that tobacco use can be reduced through a comprehensive approach including:

1. Education – as part of mandatory health theme in schools.
2. Media-based activities – review the media campaigns in international use that have been assessed and select the effective parts of one or a set of these campaigns. Initiate and maintain an intensive media campaign against smoking and especially initiation of smoking
3. Pharmacological treatment of and counselling for nicotine addiction – develop a program of reimbursement for agents shown effective (nicotine delivery systems, bupropion) preferably coupled with counselling/support program through practitioners who have taken a short program in effective counselling and who could be family doctors, nurse practitioners, psychologists, or other counsellors who each receive the same fee for counselling.
4. Regulation of tobacco advertising and promotion – support federal efforts to curtail advertising and promotion especially directed at youth.
5. Clean air regulations - especially support bylaws preventing smoking in public establishments.
6. Restriction of tobacco sales to minors, making requests for age verification mandatory as that strongly predicts compliance with the law. Support community efforts to prevent tobacco sales to minors
7. Taxation of tobacco products. An additional tax should be added to cigarettes, and directed in its entirety to paying the costs of the preceding programs including advertising and costs of pharmacological treatment and counselling. The additional cost due to added taxation will have a direct effect to reduce smoking especially among youth.
8. Community based activities – promote community efforts to limit smoking especially in youth by supporting activities such as restricted sales to minors, antismoking bylaws, smoke free workplaces, homes, and public buildings, community support of individuals attempting to overcome nicotine addiction and other rationale programs proposed and supported by communities.

A new food guide and industry collaboration

1. The Canada Food Guide is outmoded relative to modern nutritional research. It is too general a guide, and fails to provide adequate direction and emphasis to achieve optimal diets, especially to accommodate a wide range of tastes. It has a number of major problems. It does not differentiate effectively among refined versus whole grain products. There is failure to separate legumes from meat choices because they are both protein rich but are otherwise totally dissimilar and offer a totally different content of vitamins, fibre and fat types. Fish consumption is under-emphasized. Little effort is spent on discussing optimization of foods like meat. For example, there is no information on recognizing poultry skin as a major source of saturated fats. Emphasis of no fat or very low fat dairy products is inadequate. There is no mention of foods containing trans fats nor any effort to ensure sources of uncommon but essential food nutrients especially omega-3 fatty acids.

An Alberta Food Guide should be developed and specifically constructed to correspond to the best of

the most recent evidence on optimal diets for health. In particular better guidance on numbers of servings relative to activity levels, the addition of a legume food group, greater emphasis on fish servings per week, methods to avoid saturated fats and trans fats while still eating all food groups, the importance of maximizing less well refined carbohydrates versus highly refined carbohydrates, indication of foods that are rich in key minerals and vitamins, ways to diminish salt intake, and matching food labels with the food guide recommendations. The guide should provide information on how well subgroups of the major food groups meet the food guidelines of the Alberta Food Guide.

Food labelling is also outmoded in Canada but new federal labelling will be mandatory in the next 2 to 3 years. As part of the food guide some examples of using the labels to select foods would also be of great assistance.

2. Certain specific actions with the food industry should also be undertaken. The most important of these would be discussions aimed at reducing both the sodium content of prepared foods, and the trans fat content of commercial foods, especially baked goods. In return these could be promoted through the Alberta Food Guide.

Community based activity and health instruction

Alberta Health and Wellness should have a mechanism to receive and evaluate proposals from community organizations to improve the health of a community. This mechanism should encourage self funding of projects but allow for assistance from Alberta Health and Wellness in access to information, data assessment tools, and advice regarding the program. Exemplary proposals could be considered for financial assistance but that should clearly not be the normal expectation. Alberta Health and Wellness could develop a brief format for submission including the use of electronic submissions. Furthermore areas of priority such as smoking cessation, community exercise programs, self help programs for communities with special problems (e.g. infant mortality in aboriginal communities) and others could be considered.

Age group specific programs including Senior lifestyles

Alberta Health and Wellness should consider the introduction of specific wellness programs directed at target populations and using existing organizations within communities. Most towns or cities have organizations providing services to seniors. It would be useful to carry out a review, in association with these organizations, of programs offered to maintain and promote health. Following the review suggestions could be made for programs to be considered by the local organization. Resources based on the reviews carried out by the "informationist" office (recommended above) and Food Guide could be used to develop programs for seniors. For example these could take the form of cooking classes, exercise classes, smoking cessation programs, defensive classes to make the home and travel safe and to improve immunization status and screening for early detection of possible illness. Similar approaches could also be taken for other widely disseminated organizations (e.g. Cubs and Scouts, rural 4H for young people) after appropriate planning and discussions with the groups.

Different Health Providers

There is a need to enhance the range and type of health providers to achieve closer to optimal health promotion and disease prevention. Nurse practitioners have in some instances been shown to provide

more counsel and support to improve health habits. Other providers such as nutritionists and fitness instructors may play important roles to improve the key areas of dietary habits and activity especially among adults. Counsellors, including additionally trained family doctors have value for programs like smoking cessation and to encourage and support positive lifestyle changes. Many of these additional practitioners would be encouraged into the system by use of a capitation payment scheme. But their roles need to be enhanced in the short term perhaps by devoting specific salaried positions to these functions, as funds are allocated to the Regional Health Authorities.

Appendix 1- Childhood services and early childhood intervention

ALBERTA GOVERNMENT (taken from the Alberta Government Web site)

The Ministry of Children's Services offers a number of services and programs for children and families in the province, including Child Protection, Adoption Services, Day Care Programs, Family Court and Mediation Services, Family Violence Prevention, Handicapped Children's Services, and Early Intervention Programs.

Rather than Government directly delivering these programs, there are 18 Child and Family Services Authorities within Alberta that offer them to Albertans. Each of these Authorities has a board with members from within the community. They design programs in ways that best meet the needs of their region. The Authorities must meet specific standards in the way they operate. This allows for flexibility across the province while also making sure standards are reached.

OVERVIEW OF SERVICES

Child Protection
  Foster Parenting

Adoptions
  Adoption Search and Reunion

Family Court and Mediation Services

Day Care Programs

Handicapped Children's Services

Prevention of Family Violence

OTHER AREAS OF THE MINISTRY

Children's Advocate

Family and Community Support Services (FCSS)

Child & Family Services Authorities
Regional authorities have taken over the delivery of child and family services across Alberta.

Each "Child and Family Services Authority" oversees a range of services, including child welfare, day care, family violence prevention services, services for children with disabilities, early intervention programs, and court services and mediation.

This community-based system will allow services and programs to be planned on the basis of local

needs.

Overview

A new and dynamic partnership

Albertans place high priority on the safety, well-being and healthy development of children and families. Albertans have said it is time for change – time to take a positive new approach to enhance the delivery of child and family services.

This message was expressed very clearly during a series of community consultations in 1994. Albertans advised the provincial government that this new approach must allow for a greater degree of decision-making at the community level. It must recognize that community members have a deep understanding of the needs of, and challenges facing, their children and families. It must provide citizens with a range of opportunities to be involved in the planning and provision of services to children and families.

These discussions led to a dynamic new partnership between Alberta's communities and the Alberta government – a partnership that launched a major, grassroots process of social development unique in the history of Alberta. At local, regional and provincial levels, comprehensive planning is now in the advanced stages for the creation of a community-based system of child and family services.

Child & Family Services Authorities - The four pillars of the new system

Four key principles, or pillars, have guided the planning of Alberta's community-based system of child and family services.

The Four Pillars

The Four Pillars are the foundation of the redesign of services for children and families. These key areas of change were identified in consultations with Albertans.

A. Community-based services
   Communities support the principle of participation and access for all. The role of natural helpers, support networks and cultural groups will be integrated and expanded within the professional delivery of service.

B. Early intervention services
   Regions will provide an array of timely, accessible services to assist and support children and families, develop skills to build on their strengths and reduce the need for crisis intervention.

C. Improved Services for Aboriginal Children and Families
   The responsibility for planning and delivering services for Aboriginal children and families will be transferred to Aboriginal

communities to reflect the values, beliefs and customs of First Nations, Metis and other Aboriginal people in a respectful, collaborative manner.

D. Integrated Services

Planning and service delivery will be integrated at the community, regional and provincial levels to facilitate barrier-free access to holistic services for children and families.

The Players

Government of Alberta

Under Alberta law, the provincial government is accountable for services that provide for the safety, security and well-being of children and families. This does not change under the new community-based system of services. As outlined in the Child and Family Services Authorities Act, the government will:

i. set objectives, policies and standards for child and family services in Alberta;
ii. allocate funding and other resources to the Child and Family Services Authorities;
iii. monitor and assess the Authorities in the carrying out of their
iv. responsibilities.

Child and Family Services Authorities

As outlined in the Child and Family Services Authorities Act, each Authority will:

- assess needs, set priorities, plan, allocate resources, and manage the provision of services to children, families and other community members in the region;
- ensure that children and families have reasonable access to quality services;
- ensure that provincial policies and standards are followed in the region;
- monitor and assess the provision of child and family services;
- work with other Authorities, public and private bodies, and government to co-ordinate services for children and families.

The Authority board, whose members are appointed by government, will oversee these tasks. The community members on this board will provide clear and strong leadership to bring the community service system into effect. The board will work closely with communities in the region.

A chief executive officer will carry out the board's policies and decisions, manage the day-to-day operations of the Authority, and see that the regional system runs effectively.

Service-providing organizations

A variety of community agencies, organizations and individuals will continue to provide a range of services for children and families.

Community agencies may enter into contracts with an Authority. (Examples might be agencies provid-

ing treatment for children in government care, family support services, family day home services, or women's shelters.)

Child and Family Services Authorities may direct their chief executive officers to manage certain services. (For example, each Authority will manage the provision of child-protection services in its region. Child Welfare staff will be reassigned to the Authority from the government.)

Other service providers include, among others, individuals such as foster parents, operators of day care centres, and local groups which offer early intervention or other supports to meet needs of children and families in their communities.

Trained and qualified workers will continue to provide professional services in the community-based system. There will also be opportunities for volunteer helpers to offer non-professional types of support to children and families in their communities.

Partnering boards and authorities

The Child and Family Services Authorities will work with a range of community-based partners – including school boards, health authorities, mental health services, justice, Persons with Developmental Disabilities Boards, Family and Community Support Services (FCSS) and local governments. By working together, these organizations will be able to identify needs, plan and act on behalf of children and families in a co-ordinated manner. For example, children and families who have complex needs can be helped in the most effective ways when services and professionals work collaboratively, and with a focus on the individual child or family.

CROSS CANADA SURVEY ON EARLY CHILDHOD INTERVENTION (1998)
(The Government of the Northwest Territories' Joint Working Group (JWG) on Early Childhood Intervention - Survey Summary)

Organization of Early Intervention Programs/Services by Province/Territory

Province/Territory
Organization / Administration
Population Served

Newfoundland
Direct Home Services
Early Intervention staff members provide home-based services from Social Services offices in each district/region of the province. They receive program support from a Provincial Coordinator in the Ministry of Social Services
The program is a family-centered program serving children age 0 to school age who are at significant risk or have developmental delay

Province/Territory

Organization / Administration

Population Served

Prince Edward Island

No stand-alone program - services are offered under Family Support

Each of 5 Regional Health Authorities operating under the Ministry of Health and Social Services operates a Family Support Program under its Child and Family Services. Early Intervention activities consisting of home visits and other supports are part of this.

The focus is on families with children 0 to kindergarten age who require special support

Nova Scotia

Early Intervention Program

Programs operate in counties - currently 10 in operation and 3 counties without service . Programs are sponsored by community not-for profit boards and are supported by the Department of Community Services. There is a provincial coordinator.

Services are offered under a home-based program to children ages 0-5 or school entry with an established biological risk for ,or diagnosis of, developmental delay.
Some programs include children placed at risk by environmental factors.

New Brunswick

Early Intervention Program

Voluntary community boards operate 16 programs in 10 regions under contract from the Department of Health and Community Services. There is a Provincial coordinator and 10 regional coordinators — services are housed provincially within the broader Early Childhood Initiative

Programs are home-based serving children ages 0 to school age with developmental delays or at risk of developmental delay due to established risk, biological risk or environmental risk.

Quebec

No stand-alone program - services are based in local community health centres and rehabilitation centres

The Ministry of Health and Social services is responsible for provincial coordination but there does not appear to be a unified approach to Early Intervention in Quebec.

Services appear to be more organized for children with diagnosed disability or developmental delay. Some children at risk

Province/Territory

Organization / Administration

Population Served

of delay or with delay but no diagnosis may be served by centre-based programs run by community health centres. Home-based services are usually for children 0-5 years of age.

Ontario

Infant Development Programs

More than 50 of these programs operate in counties/regions across Ontario funded by the Ministry of Community and Social Services through their area/regional offices. Programs operate under the sponsorship of a wide variety of agencies including hospitals, community health centres, counselling services and associations such as the Association of Community Living. There is no provincial coordination but there is a strong Ontario Association for Infant Development which provides some coordination.

Programs generally serve children ages 0-2.5 or 3 years of age and their families, although some in more rural areas serve children 0-5. Programs are designed to serve infants who are at risk for developmental delay and their families. Risk categories include established, biological, or psychosocial.

Manitoba

No stand-alone program - services are offered under Children's Special Services

Services are delivered on a regional basis out of offices of the Department of Family Services by a Child Development Counsellor employed on a full, part-time or casual basis depending on the number of children requiring services. Services are both home-based and in daycare/nursery school settings

Services provide parents with supports and strategies to work with children ages 0 to school age with a disability or developmental delay or at risk of developmental delay — most typically does not include children at risk because of disadvantaged environments

Saskatchewan

Early Childhood Intervention Program Sask. Inc.

ECIP Sask. Inc is a non-profit organization with a Provincial Board of Advisors which coordinates 16 independent, autonomous community-based ECI programs. Funding is provided by the Department of Social Services and by Indian and Northern Affairs Canada for on-reserve programs

Programs are home-based and serve children ages 0-5 or school

Province/Territory Organization / Administration	Population Served
	entry and their families. Children served are experiencing delays in development or are at risk for delays due to established, biological or social factors
Alberta	
Early Intervention Programs Programs operate under Regional Health Authorities . Eleven health regions have full service, 2 have service in half the region and 4 regions have no service. Programs are delivered by 19 organizations such as health units, non-profit societies or school boards. Funding is by the Ministry of Health.	Programs serve children aged 0-3.5 who have developmental delays or disabilities and their families
British Columbia	
Infant Development Programs Programs are funded by the Ministry of Social Services and are delivered through 48 existing community agencies including Associations for Community Living and Family and Children's Services Societies across the province. There is a Provincial Coordinator who reports to a Provincial Steering Committee. Programs are also supported by regional advisers.	Programs offer services to families with children aged 0-3.5 whose development is delayed or at risk of delay due to genetic or health related problems and also to families with children whose development is delayed because of environmental disadvantage
Yukon	
Child Development Centre The Child Development Centre is a non-profit organization with a Board of Directors . Funding is through the Ministry of Health, user fees and donations. Early Childhood consultants operate together with Occupational Therapists, Physiotherapists and Speech and Language therapists on an Infant team, a Pre-school team and an Outreach Team to provide services across the Yukon.	The program serves children from ages 0-6 with special needs (developmental delays, behavioural or social problems, and children at risk for developing delays).

The Government of the Northwest Territories' Joint Working Group (JWG) on Early Childhood Intervention - 1998. http://siksik.learnnet.nt.ca/ECE/ecss/daycare/A/south/exec.htm